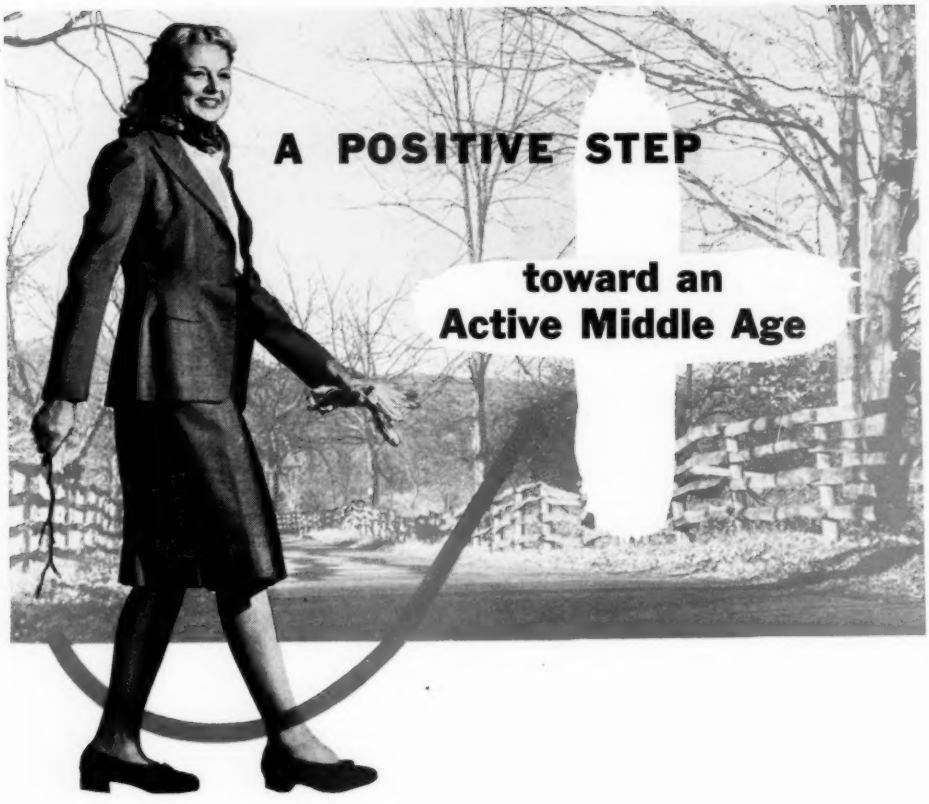
BOSTON UNIVERSITY
SCHOOL OF MEDICINE

VOLUME 3 • JANUARY 1948 • NUMBER 1

FEB 5 - 1946

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

Library of Boston University
School of Medicine.
80 E. Concord St.,
Boston, Mass.



Outstanding clinical endocrinologists, both here and abroad, have commented on the brighter mental outlook displayed by women receiving "Premarin." Not only does "Premarin" impart a feeling of "well-being" but it offers many other advantages as well.

It is orally active.
It is well tolerated.
It is promptly effective in controlling the menopausal syndrome.

"Premarin" is supplied in three potencies—tablets of 2.5 mg., 1.25 mg. and 0.625 mg. It is also available in liquid form containing 0.625 mg. in each 4 cc. (1 teaspoonful).

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present in varying small amounts, probably as water-soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

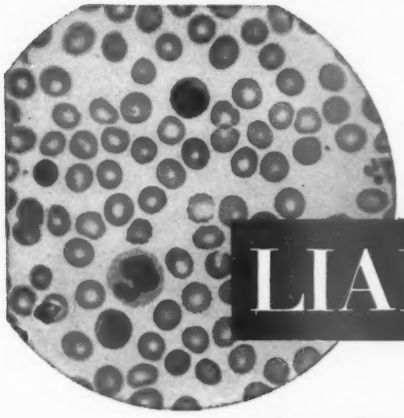
Ayerst

CONJUGATED ESTROGENS
(equine)

"Premarin"®

AYERST, McKENNA & HARRISON Limited

22 EAST 40th STREET • NEW YORK 16, N. Y.



When it is difficult to categorize the anemia

LIAFON

SQUIBB

DESICCATED LIVER
FERROUS SULFATE
ASCORBIC ACID
FOLIC ACID

A new hematinic combination for the simultaneous administration of *four therapeutic essentials*

DESICCATED LIVER: whole liver with only the water removed. Provides nutritive elements of fresh liver, including the experimentally essential, clinically impressive secondary anti-anemia fractions.

FERROUS SULFATE EXSICCATED: one of the most readily utilized, tolerated and absorbed forms of iron. For *specific treatment* of iron deficiency anemias.

ASCORBIC ACID: often a prerequisite in anemias associated with C avitaminosis. Recent work also suggests it influences iron absorption and red cell maturation.

FOLIC ACID: bone-marrow stimulant factor of the B complex, *specific* for macrocytic anemias of malnutrition, pregnancy, pellagra, and sprue; also of value with parenteral liver therapy in Addisonian pernicious anemia.

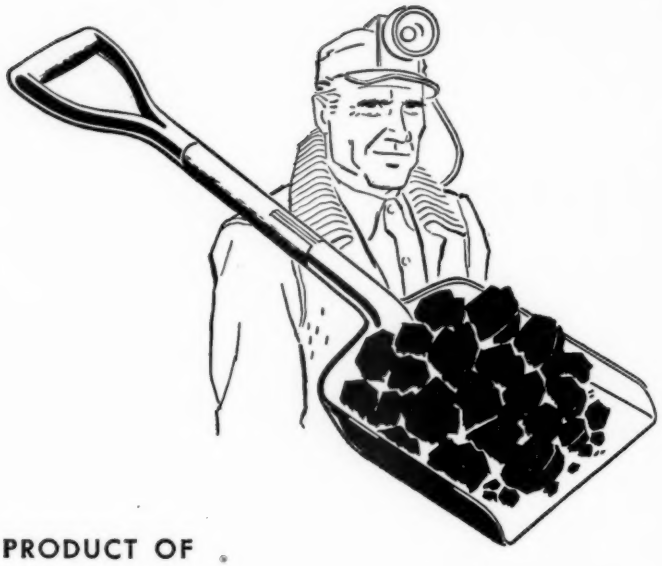
Thus, when more than one form of anemia is present or suspected, and is difficult to categorize, *Liafon provides the essentials for therapy.*

EACH LIAFON CAPSULE CONTAINS:	DOSAGE EQUIVALENTS	
	3 capsules daily	6 capsules daily
Desiccated Liver . . . . . 0.5 Gm. (Approx. equivalent to 2 Gm. whole fresh liver)	*6 Gm. fresh liver	*12 Gm. fresh liver
Ferrous Sulfate Exsiccated . . . 2.0 gr. (Approx. equivalent to 2.65 gr. ferrous sulfate)	*8.5 gr. ferrous sulfate	*17 gr. ferrous sulfate
Ascorbic Acid . . . . . 50.0 mg.	150 mg.	300 mg.
Folic Acid . . . . . 1.67 mg.	5 mg.	10 mg.

Liafon is supplied in bottles of 100 and 1,000

*Approximate equivalent

SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



PRODUCT OF

a great variety of uses

Short-acting Nembutal, too, is employed in many ways. As more reports are added to the literature each year—now over 460—more and more physicians are extending the use of Nembutal in their practice. • It is a logical procedure. They have come to know that adjusted doses can achieve any desired degree of cerebral depression, from mild sedation to deep hypnosis . . . that the dosage required is only about *one-half* that of many barbiturates. • They have learned that, with short-acting Nembutal's small dosage, there is less drug to be inactivated . . . reduced possibility of "hangover" . . . shorter duration of effect . . . wide margin of clinical safety . . . definite economy to patients. • Consequently, these physicians are using a greater variety of the 11 Nembutal products—available at your pharmacy in convenient small-dosage forms. If the list at right suggests more ways in which *you* can use Nembutal, won't you give it a trial? ABBOTT LABORATORIES, North Chicago, Illinois.

In equal oral doses, no other barbiturate combines QUICKER, BRIEFER, MORE PROFOUND EFFECT than

Nembutal®

(Pentobarbital, Abbott)

HAVE YOU TRIED Nembutal Sodium Suppositories, or palatable Nembutal Elixir, when it is not possible or feasible to give other dosage forms?

44...

OF NEMBUTAL'S CLINICAL USES

SEDATIVE

Cardiovascular
Hypertension[1]
Coronary disease[1]
Angina[1]
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[3,1]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[5,4]

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[6]

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

PEDIATRIC
Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Nembutal alone or [1]Glucophylline® and Nembutal, [2]Nembutal and Belladonna, [3]Ephedrine and Nembutal, [4]Nembudeine®, [5]Nembutal and Aspirin, [6]with scopolamine or other drugs.

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 3 JANUARY 1948 NUMBER 1

Each member of the American Medical Women's Association is entitled to receive a copy of the Journal of the American Medical Women's Association every month.

The Journal of the American Medical Women's Association is not responsible for any statement made or opinion expressed by any of its contributors.

Official monthly magazine of the American Medical Women's Association, Incorporated. Advertising and subscription offices are located at Apt. 3—1517 Center St., Little Rock, Arkansas.

ORIGINAL ARTICLES

Bullous Skin Eruptions Following Sulfonamide Administration, *Carmen C. Thomas, M.D. and Marjory K. Hardy, M.D.* 1
Obstetrical Risks, *Ann Gray Taylor, M.D.* 4
Tropical Medicine, Parts XV (Conclusion) and Part XVI, *Carroll LaFleur Birch, M.D.* 6
Recent Advances in Pediatrics, *May Borquist Guy, M.D.* 14

INTERNATIONAL SECTION

Message from the President of the Medical Women's International Association 19
The World Medical Association 19
The Pre-War German Medical Association, *Esther P. Lovejoy, M.D.* . . 20
International Interlude, *H. E. Thelander, M.D.* 23
International Congress of Obstetricians and Gynecologists, *Eva F. Dodge, M.D.* 23
Fourth International Cancer Research Congress, *Georgiana Bonser, M.D.* 24
Message from a Foreign visiting Doctor 25

EDITORIAL PAGE

Editorials and Announcements 26

ORGANIZATION

New Members 27
Application Blank 27

REGULAR FEATURES

Opportunities for Medical Women 28
Current Publications of Women in Medicine 31
Book Reviews 34
News of Medical Women 36
Medical School News, *Eva F. Dodge, M.D.* 37
From Day to Day, *Ada Chree Reid, M.D.* 38

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., N., Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 15, 1918.

Copyright 1948 by the American Medical Women's Association, Inc.

Subscription price, $3.00 per year; 35c single copy.

INFORMATION FOR AUTHORS

The Journal of the American Medical Women's Association invites articles on any subject of interest to the medical profession.

Manuscripts should be sent to the Editor, Dr. Elise S. L'Esperance, 2 East 61st Street, New York 21. They should be typewritten, on one side of the paper only, double spaced, with wide margins. References should be placed at the end of the article, and should follow the form of the Quarterly Cumulative Index Medicus. A carbon copy of the article should be retained by the author, and a second carbon copy included with the original manuscript. The name and address of the author must appear on the manuscript. Articles are accepted for publication with the understanding that they are submitted only to the **Journal.**

The **Journal** and the publishers are not responsible for manuscripts, illustrations, or charts, lost in transit.

A reasonable number of cuts will be supplied to illustrate an article. Additional cuts will be charged to the author. Photographs submitted must be glossy prints. Drawings must be in black ink. Illustrations must be marked on the back with the name of the author, title of the paper, figure number, etc., and the top of the picture should be indicated. Legends should be typewritten on a separate sheet, giving the above data.

Fifty reprints, without covers, will be furnished free of charge. Additional reprints will be supplied at cost, if request is made at the time the corrected proof is returned by the author.

PRICE OF REPRINTS

Journal of The American Medical Women's Association

Copies	100	200	300	400	500	600	700	800	900	1000
2 Pages	7.20	8.00	8.85	9.75	10.60	11.40	12.20	13.00	13.80	14.60
4 Pages	11.00	13.00	14.40	16.10	17.80	19.35	20.80	22.35	23.80	25.25
8 Pages	20.75	23.40	26.00	28.75	31.40	33.80	36.20	38.60	41.00	43.30

NOTE: **Reprints must be ordered within 30 days after date of issue in which article appeared.**

SPECIAL NOTICE

Below is noted a list of the firms who at the present time are advertising in the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. We appreciate their interest in our publication and ask our members to favor them whenever possible.

Abbott Laboratories
Ayerst, McKenna & Harrison, Ltd.
Coca-Cola Company
Durex Products, Inc.
Mead Johnson & Company
Lanteen Medical Laboratories, Inc.
Eli Lilly & Company
Merck & Company, Inc.
Ortho Pharmaceutical Corporation
Parke, Davis & Company
Picker X-Ray Corporation
Schering Corporation
Spencer, Inc.
Squibb
Martin H. Smith Company
Swift & Company
Tampax, Inc.
Upjohn Company
White Laboratories, Inc.

Enlarged tonsils interfere with respiration, cause dysphagia, frequent sore throats, offensive breath and coughing. Complete tonsillectomy is only adequate treatment.

Pronounced hyperemia, edema and purulent exudate from tonsillar crypt, appearing as punctate whitish spots on surface of tonsillar mucous membrane.

"SALIVARY ANALGESIA"

FOR RELIEF IN:

. . . acute and chronic tonsillitis

. . . the post-tonsillectomy state

. . . dry, irritated "post-partum" throat

. . . pain following instrumentation of esophagus or larynx

. . . coryza, grippe, non-specific upper-respiratory infections

. . . fever and pain in children

Dillard's Aspergum combines marked local relief of pain with a general analgesic and antipyretic effect. It increases the salivary flow; stimulates activity of muscles of mastication and deglutition; reduces local spasticity and stiffness; thereby hastening convalescence and encouraging an early return to a full diet.

A particularly acceptable antipyretic-analgesic for children.

Ethically promoted. In packages of 16, moisture-proof bottles of 36 and 250.

White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

Dillard's **ASPERGUM**

Salivary Analgesia—Plus

quick-acting . . . safe . . . topical chemotherapy in oropharyngeal infections

The speedy response obtained with White's Sulfathiazole Gum—coupled with the safety factor of its low systemic absorption—account for its wide prescription use in oral, tonsillar and pharyngeal infections.

HIGH LOCAL CONCENTRATION

Prompt and long-sustained in effect; the sulfonamide is maintained in intimate, therapeutically effective concentration throughout entire oropharyngeal area.

NEGLIGIBLE SYSTEMIC ABSORPTION

Even with maximal dosage, blood sulfonamide levels are usually quantitatively immeasurable, virtually obviating likelihood of systemic toxic reactions.

STABLE

Full potency is retained under all conditions.

CLINICALLY ACCEPTED

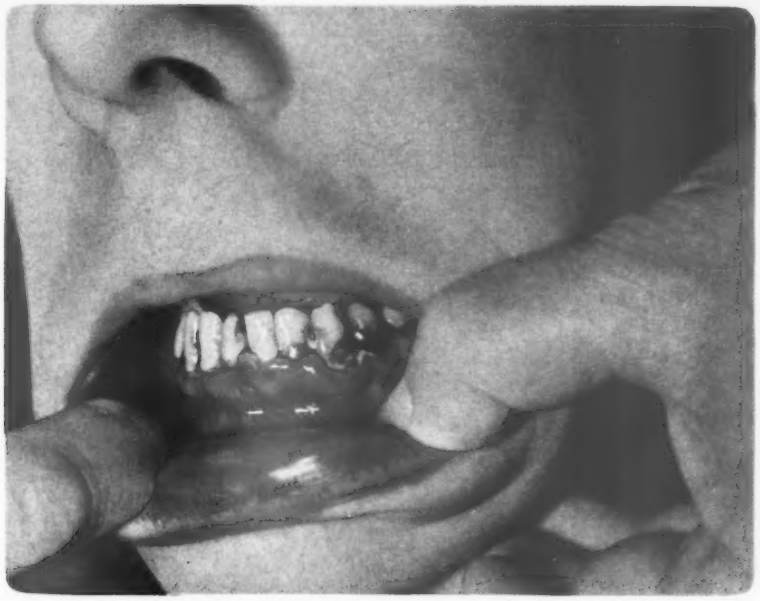
Established by long and extensive clinical use.

Supplied in packages of 24 tablets, sanitaped, in slip-sleeve prescription boxes. IMPORTANT: Please note that your patient requires your prescription to obtain this product from the pharmacist.

White's SULFATHIAZOLE GUM*

Safe, Topical Chemotherapy

*A Product of White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.



FUSOSPIROCHETAL GINGIVITIS (*Plaut-Vincent's Infection*), *Acute*

Characteristic punched-out lesions appearing on the interdental papillae and marginal gingivae. Slight pressure causes pain and bleeding on these areas. The dirty white pseudomembrane present in most acute cases is illustrated.

FUSOSPIROCHETAL GINGIVITIS (*Plaut-Vincent's Infection*), *Acute, Healed*

This is a healthy mouth. After treatment with Sulfathiazole Gum for 72 hours, the patient presents normal, healthy gingival borders and all evidence of inflammation has receded.

Topical Otologic Chemotherapy of Choice...

Maximum effectiveness is obtained by local instillation of Otomide in affected cases at least three times daily.

. . . in BOTH acute AND chronic infections

Otomide brings about prompt and sustained analgesic-antipruritic effects through the topical action of chlorobutanol. The urea-sulfonamide mixture exerts an anti-bacterial effect definitely greater than that produced by either drug alone. A valuable adjunct to systemic treatment.

Infections contaminated with fungi have been effectively treated with Otomide since sulfanilamide is more fungistatic than other sulfonamides or penicillin.

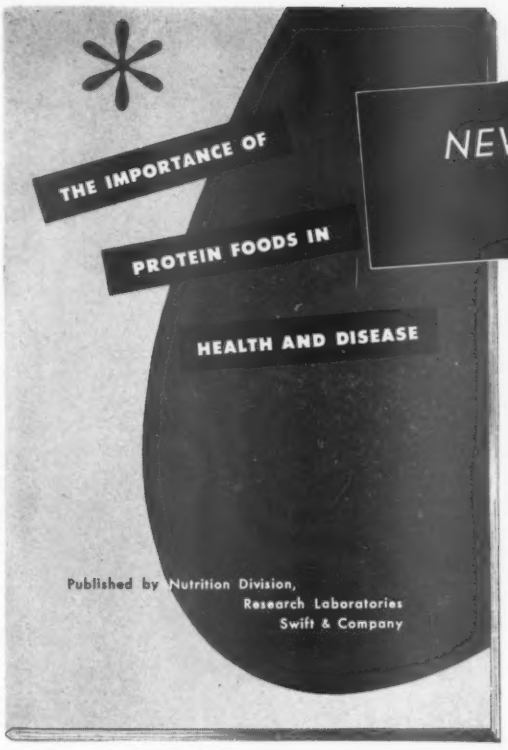
Topical Otologic Chemotherapy

White's OTOMIDE

A stable solution of 5% Sulfanilamide, 10% Urea (Carbamide), 3% Anhydrous Chlorobutanol in a specially processed glycerin vehicle of unusually high hygroscopic activity.

IN DROPPER BOTTLES OF ½ FLUID OUNCE (15 CC.)

WHITE LABORATORIES, PHARMACEUTICAL MANUFACTURERS, NEWARK, N. J.



NEW . . . physician's handbook of protein-feeding

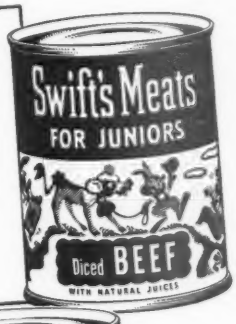
"The Importance of Protein Foods in Health and Disease"

Free — let us send you a copy now

Written by a practicing physician, in conjunction with the Nutrition Division of Swift & Company, this booklet provides a convenient source of reference for all the important, new, published findings concerning the value of protein in the human diet.

The booklet is broad in its scope, covering the subject from *the general significance of protein in nutrition* to specific *clinical aspects*. In addition, high-caloric, high-protein diets—for both oral and tube-feeding—are included. "The Importance of Protein Foods in Health and Disease" provides a practical, working handbook of protein feeding. Let us send you your copy now. Simply write Swift & Company, Dept. S.M.B., Chicago 9, Illinois.

Also Swift's Diced Meats . . . where textures of foods indicated may be less fine, you may find these tender, juicy cubes of meat desirable.



All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

Palatable answer to many problems of protein supplementation

The new Swift's Strained Meats are being used more and more in soft diets where a high-protein intake is indicated. The six kinds of Swift's Strained Meats—beef, lamb, pork, veal, liver and heart—provide an exceptionally palatable source of *complete, high-quality proteins*, B vitamins and iron. Developed originally for infants, Swift's Strained Meats are 100% meat, soft and fine in texture—easily adaptable to tube-feeding.

The booklet "The Importance of Protein Foods in Health and Disease" is accompanied by a supplementary pamphlet containing simplified high-protein diets, for both oral and tube-feeding, using Swift's Strained Meats. Send for your copy today.

SWIFT & COMPANY
Chicago 9, Illinois

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION

Editorial Board

JANET K. AITKEN, M.D., F.R.C.P. . . . . *London, England*
INÉS L.C. DE ALLENDE, M.D. . . . . *Cordoba, Argentina*
LEONA BAUMGARTNER, M.D. . . . . *New York, N. Y.*
CARROLL LAFLEUR BIRCH, M.D. . . . . *Chicago, Ill.*
NINA FAY CALHOUN, M.D. . . . . *Dallas, Texas*
MARY M. CRAWFORD, M.D. . . . . *New York, N. Y.*
BEULAH CUSHMAN, M.D. . . . . *Chicago, Ill.*
MARIA PAUMGARTTEN DEANE, M.D. . . . . *Belem, Pará, Brazil*
GLADYS H. DICK, M.D. . . . . *Chicago, Ill.*
DELLA GAY DRIPS, M.D. . . . . *Rochester, Minn.*
FAITH S. FETTERMAN, M.D. . . . . *Philadelphia, Pa.*
RITA S. FINKLER, M.D. . . . . *Newark, N. J.*
GRACE A. GOLDSMITH, M.D. . . . . *New Orleans, La.*
EDNA M. GUEST, O.B.E., M.D. . . . . *Toronto, Canada*
ANNA HUBERT, M.D. . . . . *New York, N. Y.*
HELEN JOHNSTON, M.D. . . . . *Des Moines, Iowa*
ZOE ALLISON JOHNSTON, M.D. . . . . *Pittsburgh, Pa.*
MARGARET H. JONES, M.D. . . . . *Los Angeles, Calif.*
JOSEPHINE H. KENYON, M.D. . . . . *New York, N. Y.*
ELIZABETH KITTREDGE, M.D. . . . . *Washington, D. C.*
LEILA C. KNOX, M.D. . . . . *New York, N. Y.*
IRENE A. KOENEKE, M.D. . . . . *Halstead, Kansas*
ESTHER P. LOVEJOY, M.D. . . . . *New York, N. Y.*
CATHARINE MACFARLANE, M.D. . . . . *Philadelphia, Pa.*
HELEN MACMURCHY, C.B.E., M.D. . . . . *Toronto, Canada*
MINNIE LEE MAFFETT, M.D. . . . . *Dallas, Texas*
DAME A. LOUISE MCILROY, O.B.E., M.D. . . . *London, England*
HARRIET C. MCINTOSH, M.D. . . . . *New York, N. Y.*
ANITA M. MUHL, M.D. . . . . *San Diego, Calif.*
DOROTHY KLENKE NASH, M.D. . . . . *Pittsburgh, Pa.*
LOUISE PEARCE, M.D. . . . . *Princeton, N. J.*
GILDA PERAZA, M.D. . . . . *Havana, Cuba*
ELLEN C. POTTER, M.D. . . . . *Trenton, N. J.*
BARBARA B. STIMSON, M. D. . . . . *New York, N. Y.*
MARGARET C. TOD, F.R.C.S.E., F.F.R. . . . *Manchester, England*
EDNA H. TOMPKINS, M.D. . . . . *New Haven, Conn.*
RUTH WELLS, M.D. . . . . *Pasadena, Calif.*
PRISCILLA WHITE, M.D. . . . . *Boston, Mass.*
KATE SAVAGE ZERFOSS. M.D. . . . . *Nashville, Tenn.*

Specialists

Anesthesia . . . . LOIS L. WELLS, M.D., *Oklahoma City, Okla.*
Gynecology . . . . . ELOISE PARSONS, M.D., *Chicago, Ill.*
Medicine . . MARION N. GIBBONS, M.D., *Shaker Heights, Ohio*
Obstetrics . . . . ISABEL KNOWLTON, M.D., *New York, N. Y.*
Orthopedic Surgery . . . RUTH JACKSON, M.D., *Dallas, Texas*
Pathology . . . . . SOPHIE SPITZ, M.D., *New York, N. Y.*
Pediatrics . . . . MAY BORQUIST GUY, M.D., *Seattle, Wash.*
Psychiatry . . . . . JOAN FLEMING, M.D., *Chicago, Ill.*
Public Health . . HELEN M. WALLACE, M.D., *New York, N. Y.*
Radiology . . HARRIET C. MCINTOSH, M.D., *New York, N. Y.*
Surgery . MARGARET STANLEY-BROWN, M.D., *New York, N. Y.*

EDITOR

ELISE S. L'ESPERANCE, M.D.
Two East 61st Street
New York 21, N. Y.

ASSISTANT EDITOR

ADA CHREE REID, M.D.
One Madison Avenue
New York 10, N. Y.

ASSISTANT EDITOR

DOROTHY WELLS ATKINSON, M.D.
490 Post Street
San Francisco 2, California

COMMITTEE ON PUBLICATION

Chairman
HELEN F. SCHRACK, M.D.
216 North Fifth St.
Camden, N. J.

ADVERTISING AND BUSINESS MANAGER

MRS. FRANCES MERCER
Apt. 3
1517 Center St.
Little Rock, Arkansas

DISTINCTIVE

ESTINYL* (ethinyl estradiol) is distinctive among oral estrogens.

Ethinyl estradiol is a derivative of the true follicular hormone, alpha-estradiol. It is more potent, milligram for milligram, than any other oral estrogen, natural or synthetic, in clinical use today.

It induces that therapeutically important "sense of well-being" characteristic of the natural estrogens. Its cost is low, making it available to all women.

It offers the convenience of estrogen therapy by mouth; and provides relief with a rapidity almost equal to parenteral hormone treatment.

ESTINYL

(ethinyl estradiol)

DOSAGE: One ESTINYL Tablet of 0.05 mg. daily. In severe cases two to three tablets may be prescribed daily and dosage reduced as symptoms are alleviated.

ESTINYL (ethinyl estradiol) Tablets of 0.05 mg. (pink) and 0.02 mg. (buff), in bottles of 100, 250 and 1,000. ESTINYL Liquid, 0.03 mg. per 4 cc., in bottles of 4 and 16 oz.

*®

SCHERING

Schering CORPORATION • BLOOMFIELD, N. J.

In Canada, Schering Corporation Limited, Montreal

AMERICAN MEDICAL WOMEN'S ASSOCIATION

1947-1948

Annual Meeting: Blackstone Hotel, Chicago, Illinois—June 19-20, 1948

OFFICERS

President
MABEL E. GARDNER, M.D.
129 S. Main St., Middletown, Ohio

President-Elect
ELISE S. L'ESPERANCE, M.D.
Two East 61st St., New York 21, N. Y.

Retiring President
HELEN JOHNSTON, M.D.
1314 Equitable Bldg., Des Moines 9, Iowa

First Vice-President
DOROTHY W. ATKINSON, M.D.
490 Post St., San Francisco 2, Calif.

Second Vice-President
RUTH G. ALEMAN, M.D.
2329 S. Carrollton Ave., New Orleans 18, La.

Recording Secretary
AUGUSTA WEBSTER, M.D.
104 S. Michigan Ave., Chicago, Ill.

Corresponding Secretary
HELENA T. RATTERMAN, M.D.
126 Wm. Taft Road, Cincinnati 19, Ohio

Treasurer
MARY RIGGS NOBLE, M.D.
Bowmansdale, Cumberland County, Pa.

REGIONAL DIRECTORS

New England
ELIZABETH WELLS, M.D. (1944-'47)
30 W. Beacon St., Hartford 5, Conn.

North Atlantic
DOROTHY M. ROGERS, M.D. (1946-'49)
50 Cooper St., Woodbury, N. J.

Middle Atlantic
H. GLADYS KAIN, M.D. (1945-'48)
1801 Eye St., N.W., Washington 6, D. C.

South Atlantic
AMEY CHAPPELL, M.D. (1945-'48)
11 Seventeenth St., N.E., Atlanta, Ga.

Northeast Central
EVANGELINE E. STENHOUSE, M.D. (1947-'50)
55 E. Washington St., Chicago 2, Ill.

Southeast Central
LUCY SCOTT HILL, M.D. (1945-'48; elected '47)
2000 Tulane Ave., New Orleans 19, La.

Northwest Central
JEAN JONGEWAARD, M.D. (1946-'49)
Jefferson, Iowa

Southwest Central
CORA DYCK, M.D.
Moundridge, Kansas

North West
MIRIAM LUTEN, M.D. (1947-'50)
105 N.E. 61st St., Apt. 10, Portland 16, Oregon

South West
ANITA GELBER, M.D. (1947-'50)
1052 West Sixth St., Los Angeles, Calif.

CHAIRMEN OF STANDING COMMITTEES

American Women's Hospitals
ESTHER P. LOVEJOY, M.D.
50 West 50th St., New York, N. Y.

Auditing
BEULAH CUSHMAN, M.D.
25 E. Washington St., Chicago 2, Ill.

Credentials Committee
ELIZABETH MASON-HOHL, M.D.
671 N. Mariposa Ave., Los Angeles 4, Calif.

Emergency Aid for Women Physicians
RITA S. FINKLER, M.D.
35 Leslie St., Newark 8, N. J.

Executive
MABEL E. GARDNER, M.D.
129 S. Main St., Middletown, Ohio

Finance
ADA CHREE REID, M.D.
One Madison Ave., New York 10, N. Y.

History of Medicine
ELISABETH MARTIN, M.D.
56—5th St., N.E., Atlanta, Ga.

International Relations
HELEN JOHNSTON, M.D.
1314 Equitable Bldg., Des Moines 9, Iowa

Legislation
MARGARET NICHOLSON, M.D.
1801 Eye St., N.W., Washington 6, D.C.

Library
BERTHA VAN HOOSEN, M.D.
25 E. Washington St., Chicago 2, Ill.

Medical Education for Women
MINNIE L. MAFFETT, M.D.
706 Medical Arts Bldg., Dallas, Texas

Nominations
DORA F. SONNENDAY, M.D.
145 W. McMillan St., Cincinnati 19, Ohio

Opportunities for Medical Women
H. E. THELANDER, M.D.
384 Post St., San Francisco 8, Calif.

Organization and Membership
FAITH W. REED, M.D.
2327 Canterbury Road, University Heights, Cleveland, Ohio

Publication Committee
HELEN F. SCHRACK, M.D.
216 N. Fifth St., Camden, N. J.

Public Health
CARROLL LAFLEUR BIRCH, M.D.
1853 W. Polk St., Chicago, Ill.

Public Relations
ELISE S. L'ESPERANCE, M.D.
Two East 61st St., New York 21, N. Y.

Reference
KATE SAVAGE ZERFOSS, M.D.
165 Eighth Ave., N., Nashville 3, Tenn.

Scholarship Awards
FRANCES HANNETT, M.D.
5490 So. Shore Drive, Chicago 15, Ill.

Scholarship Funds
IRENE A. KOENEKE, M.D.
Halstead, Kansas

Woman's Medical College of Pennsylvania
CATHARINE MACFARLANE, M.D.
701 Medical Arts Bldg., Philadelphia, Pa.

CHAIRMEN OF SPECIAL COMMITTEES

Annual Meeting
KATHARINE W. WRIGHT, M.D.
811 Lincoln Street, Evanston, Ill.

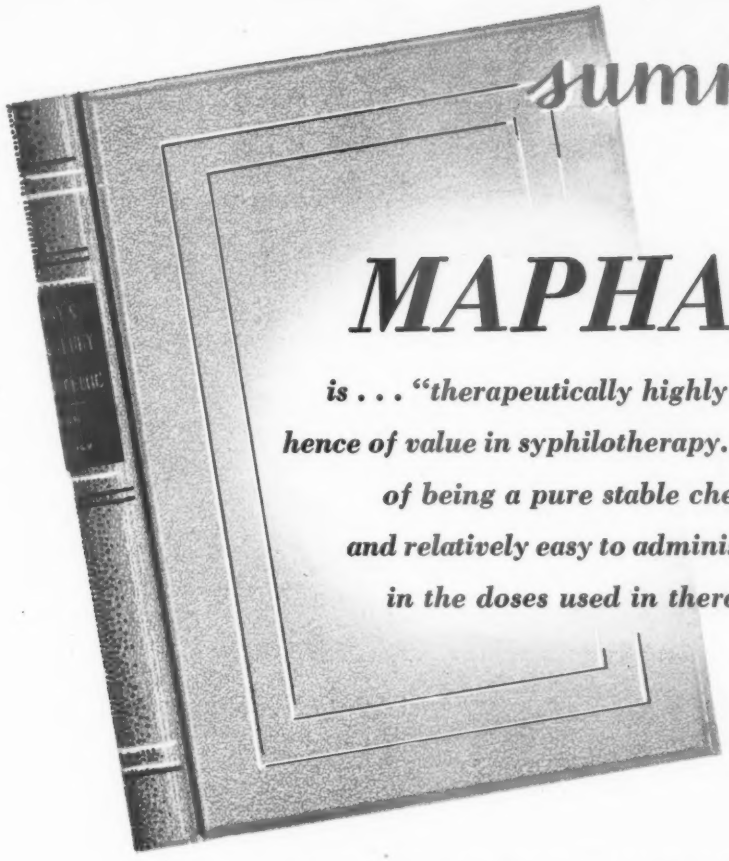
Brochure
BERTHA VAN HOOSEN, M.D.
25 E. Washington St., Chicago, Ill.

Elections
MARY B. CAMPBELL, M.D.
74 West Adams St., Detroit, Mich.

Woolley Memorial
THERESA SCANLON, M.D.
123 E. 58th St., New York, N. Y.

Elizabeth Blackwell Stamp
ADA CHREE REID, M.D.
One Madison Ave., New York, N. Y.

Mid-Year Meeting
ESTHER MARTING, M.D.
Conner's Landing, New Richmond, Ohio



summing up:

MAPHARSEN®

is . . . "therapeutically highly effective and hence of value in syphilotherapy. It has the advantage of being a pure stable chemical substance and relatively easy to administer, and in the doses used in therapy, well tolerated."*

Disappearance of spirochetes, healing of lesions, and reversal of seropositivity in a large percentage of cases in series after series attest its spirocheticidal effectiveness. Equally adapted to the intensive, the intermediate or conventional prolonged treatment schedules, MAPHARSEN is

an arsenical of choice in antiluetic therapy.

MAPHARSEN (oxophenarsine hydrochloride, P. D. & Co.) is supplied in single dose ampoules of 0.04 Gm. and 0.06 Gm., boxes of 10, and in multiple dose ampoules of 0.6 Gm. in boxes of 10.

*Cushny, A. R.: Pharmacology and Therapeutics, 13th Ed., Lea & Febiger, Philadelphia, 1947, p. 183.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

MEDICAMENTA VERA · PD & CO.

AMERICAN MEDICAL WOMEN'S ASSOCIATION

1947-1948 BRANCH OFFICERS

ONE, WASHINGTON, D. C.

President: Grace G. Purse, M.D., 1801 Eye St., N.W.
Recording Secretary: Paula Kaiser, M.D., 2407 15th St., N.W.
Corresponding Secretary: Cecile Fusfeld, M.D., 2026 R St., N.W.
Treasurer: Elizabeth Kahler, M.D., 1901 Wyoming Ave., N.W.

TWO, CHIGAGO, ILLINOIS

President: Luella E. Nadelhoffer, M.D., 6 N. Michigan Ave., Chicago.
President-Elect: Katharine W. Wright, M.D., 811 Lincoln St., Evanston, Ill.
First Vice-President: Mary Karp, M.D., 250 E. Superior St., Chicago.
Second Vice-President: Alice K. Hall, M.D., 25 E. Washington St., Chicago 2.
Secretary: Ruth E. Taylor, M.D., 5836 Etony Island Ave., Chicago.
Treasurer: Ethel M. Davis, M.D., 4742 Ellis Ave., Hyde Park Sta., Chicago.

THREE, MARYLAND

President: Amelia E. Link, M.D., 2211 E. Lake Ave., Baltimore 3.
Secretary: Lucille Caldwell, M.D., Wyman Park Apts., Baltimore.
Treasurer: Eleanor Scott, M.D., 5600 Pimlico Rd., Baltimore 9.

FOUR, NEW JERSEY

President: Elizabeth Brackett, M.D., 371 Franklin Avenue, Nutley.
First Vice-President: Hannah Seitzick-Robbins, M.D., 725 West State Street, Trenton.
Second Vice-President: Dorothy Frame, M.D., 15 Highland Avenue, Glen Ridge.
Third Vice-President: Margaret M. Wurts, M.D., 27 East Wellesley Road, Montclair.
Treasurer: Dorothy Berney, M.D.
Recording Secretary: Virginia Wuerthele, M.D., 560 Mt. Prospect Avenue, Newark.
Corresponding Secretary: Gladys Winter, M.D., 790 Grange Rd., Teaneck.

FIVE, PORTLAND, OREGON

President: Miriam Luten, M.D., 105 N.E. 61st St., Apt. 10.
Secretary: Laura Ladd, M.D., Medical Arts Bldg.
Treasurer: Dorothy Vinton, M.D., 680 Medical Arts Bldg.

SIX, OMAHA, NEBRASKA

President: Aileen E. Mathiasen, M.D., 724 First Ave., Council Bluffs, Iowa.
Vice-President: Nancy Catania, M.D., 418 Bradeis Theater Bldg., Omaha.
Secretary-Treasurer: Elinor E. Marsh, M.D., 532 First Ave., Council Bluffs, Iowa.

SEVEN, THE CAROLINAS

President: Anna M. Gove, M.D., 517 Highland Avenue, Greensboro, N. C.

EIGHT, NEW ORLEANS

Chairman: Jeanne C. Roeling-Hanley, M.D., 3501 Napoleon Ave., New Orleans 15.
Vice-Chairman: Adele Simmons, M.D., 7824 Freret, New Orleans.
Secretary-Treasurer: Cordelia Gaskill, M.D., 4900 St. Charles Ave., New Orleans.

NINE, CONNECTICUT

President: Margaret Tyler, M.D., 158 Whitney Ave., New Haven 11.
Vice-President: Edith Jackson, M.D., New Haven Hospital, New Haven.
Secretary-Treasurer: Louise de Schwenitz, M.D., 68 Bedford Ave., Hamden 14.

TEN, WISCONSIN

President: Nina T. Mueller, M.D., 2946 N. Cambridge Ave., Milwaukee 11.
Vice-President: May Neville Bielefeld, M.D., 2809 N. 56th St., Milwaukee.
Secretary-Treasurer: Mary Broadbent, M.D., 1018 N. Jefferson St., Milwaukee.

ELEVEN, SOUTHWESTERN OHIO

President: Henrietta Marie Miller, M.D., 3858 Drake Ave., Cincinnati 9.
Secretary: Helena T. Ratterman, M.D., 126 Wm. H. Taft Road, Cincinnati.

TWELVE, COLUMBUS, OHIO

President: Frances Harding, M.D., 433 E. Granville Road, Worthington, Ohio.
Secretary: Edna F. Patterson, M.D., 2483 E. Main St., Columbus, Ohio.

THIRTEEN, SAN DIEGO

President: Cornelia Robertson, M.D., 1203 Bank of America, 625 Broadway, San Diego 1.
Vice-President and Program Director: Antoinette Le Marquis, M.D., Medico-Dental Bldg., 233 A St., San Diego 1.
Treasurer: Emily Brownell, M.D., 4043 First St., San Diego.
Secretary: Anne Geiger, M.D., 1029 Sutter St., San Diego.

FOURTEEN, NEW YORK CITY

President: Elaine Ralli, M.D., 138 East 36th St.
First Vice-President: Adelaide Romaine, M.D., 35 West Ninth St.
Second Vice-President: Mary Jennings, M.D., 349 East 49th St.
Secretary: Leoni Neumann Claman, M.D., 40 East 88th St.
Treasurer: Georgia Reid, M.D., 10 West 95th St.

FIFTEEN, CLEVELAND

President: Linda Tischer Schneider, M.D., 3494 Lee Road, Shaker Heights 20, Ohio.
Vice-President: Helena Hoelscher, M.D.
Secretary: Rose M. Petti, M.D., 16374 Euclid Ave., East Cleveland.
Treasurer: Chassia G. Levin, M.D., 3482 E. 150th St., Cleveland.

(Continued on page xii)

DIENESTROL

is a new potent,
orally effective estrogen—
a major contribution to the
field of hormone therapy.

DIENESTROL

exerts a potent estrogenic effect
in unusually low doses—
0.1 to 0.5 mg. daily
in the average menopausal case.

DIENESTROL

is reported in all
clinical studies to date to effect
complete control of menopausal
or hypo-ovarian symptoms
with an incidence
of side-reactions of less than 1%.

DIENESTROL

is synthesized under
an original process
which permits comparatively
low cost to patient.

Supplied in small coated tablets of 0.1 mg. (white) and 0.5 mg. (red) in bottles of 100 and 1000.

ACCEPTED
COUNCIL ON PHARMACY AND CHEMISTRY
AMERICAN MEDICAL ASSOCIATION

White's

DIENESTROL TABLETS

WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, New Jersey

AMERICAN MEDICAL WOMEN'S ASSOCIATION

1947-1948 BRANCH OFFICERS (continued)

SIXTEEN, PITTSBURGH

President: Dorothy K. Nash, M.D., 4136 Bigelow Blvd., Pittsburgh 13.
Vice-President: Rebecca McConnell, M.D., 1010 Professional Bldg., Pittsburgh.
Secretary-Treasurer: Irene D. Ferguson, M.D., 1213 Denniston Ave., Pittsburgh.
Recording Secretary: Theodora P. Dakin, M.D., 4925 Friendship Ave., Pittsburgh.
Censors: Pauline M. Kirk, M.D., (Three years), State Hospital, Woodville, Penna.; Alice S. Gularski, M.D., (Two years), Jenkins Arcade, Pittsburgh 22; Reuben G. Alley, M.D., (One year), West Penn Hosp., Pittsburgh.

SEVENTEEN, ILLINOIS

President: Nettie Dorris, M.D., Paris, Illinois.
Secretary-Treasurer: Susan A. Slakis, M.D., 861 So. State St., Iincoln, Illinois.

EIGHTEEN, UPPER NEW YORK

Treasurer: Marguerite P. McCarthy-Brough, M.D., 1811 West Genessee St., Syracuse.

NINETEEN, IOWA STATE

President: Nelle T. Schultz, M.D., 106 N. Taft St., Humboldt, Iowa.
President-Elect: Julia Hill, M.D., 944 37 Street, Des Moines.
Vice-President: Aileen Mathiasen, M.D., Council Bluffs.
Secretary: Virginia Thompson, M.D., 685 14th Place, Des Moines.
Treasurer: Ellen Fereugal, M.D., Mitchellville.

TWENTY, BLACKWELL

President: Gertrude F. Mitchell, M.D., 650 West Bethume, Detroit 2, Mich.
President-Elect: Grace M. Perdue, M.D., 763 Fisher Bldg., Detroit, Mich.
Secretary: Betty B. Owen, M.D., 1078 Fisher Bldg., Detroit, Mich.
Treasurer: Delma F. Thomas, M.D., 753 Fisher Bldg., Detroit, Mich.

TWENTY-ONE, COLORADO STATE

President: Elsie Seelye Pratt, M.D., 737 Republic Building, Denver.
Secretary: Edna M. Reynolds, M.D., 227 16th St., Denver.

TWENTY-TWO, ST. LOUIS

President: Emmy Ross Boeckelman, M.D.
Secretary-Treasurer: Bernice Torin, M.D., 6983 Cornell Ave., St. Louis.

TWENTY-THREE, LOS ANGELES DISTRICT

President: Olga McNeile, M.D., 1401 S. Hope St., Los Angeles.
Vice-President: Vera Faegle, M.D., 4405 West 10th St., Los Angeles 6.
Recording Secretary: V. Cecile Chavannes, M.D., 3809½ Main St., Culver City, Calif.
Corresponding Secretary: Gertrude C. Seabolt, M.D., 803 Grand Ave., South Pasadena.
Program Chairman: Anita Gelber, M.D., 1052 West Sixth St., Los Angeles.

TWENTY-FOUR, KANSAS

President: M. Townsend Glassen, M.D., Phillipsburg.
Secretary-Treasurer: Ruth Spiegel, M.D., Formosa.

TWENTY-FIVE, PHILADELPHIA

President: Frieda Baumann, M.D., 1930 Chestnut Street, Philadelphia, Penna.
Vice-President: Dorothy Ashton, M.D., 1930 Chestnut Street, Philadelphia, Penna.
Secretary: Dora Ruland, M.D., 6445 Greene Street, Philadelphia, Penna.
Treasurer: Jean Crump, M.D., 1930 Chestnut Street, Philadelphia, Penna.

TWENTY-SIX, MINNESOTA

President: Nora Winther, M.D., 515 Medical Arts Bldg., Minneapolis 2.
Vice-President: Alice Harrison Fuller, M.D., 1610 West Lake Street, Minneapolis 8.
Secretary-Treasurer: Hilda Luck, M.D., 531 North 4th Street, Mankato.

TWENTY-SEVEN, OKLAHOMA

President: Eleanora Schmidt, M.D., 302 Park Drive, Norman.
Secretary-Treasurer: Iva Merritt, M.D., 650 Lindsay Road, Norman.

TWENTY-EIGHT, SPOKANE

TWENTY-NINE, ATLANTA

President: Elizabeth Martin, M.D., 756 Cypree St., N.E., Atlanta.
Vice-President: Jane Williams, M.D., 768 Juniper St., N.E., Atlanta.
Recording Secretary-Treasurer: Margaret V. Burns, M.D., Agnes Scott College, Decatur, Ga.
Corresponding Secretary: Estelle Boynton, M.D., 26 Linden Ave., N.E., Atlanta.

THIRTY, UPPER CALIFORNIA

President: Pearl S. Pouppirt, M.D., 490 Post St., San Francisco 2.
Vice-President: Grace Talbot, M.D., 909 Hyde St., San Francisco.
Secretary: A. Maximova-Kulaev, M.D., 516 Sutter St., San Francisco.
Treasurer: Elizabeth Hicks, M.D., 350 Post St., San Francisco 8.
Director: Helen B. Weyrauch, M.D., 516 Sutter St., San Francisco 2.

THIRTY-ONE, MISSISSIPPI

President: Virginia Howard, M.D., Hotel Edwards, Jackson, Miss.
Vice-President: Agnes Carr Thorpe, M.D., Jackson, Miss.
Secretary: Virginia Small Lueckenbach, M.D., Greenville, Miss.
Treasurer: Estelle A. Magiera, M.D., Child Guidance Dept., State Board of Health, Jackson, Miss.

THIRTY-TWO, WESTERN NORTH CAROLINA

Chairman: Sprinza Weizenblatt, M.D., 709 New Medical Bldg., Asheville, N. C.
Vice-Chairman: Emma S. Fink, M.D., Crossnore, N. C.
Secretary: Mary Frances Shuford, M.D., 50 Orange St., Asheville, N. C.

(Continued on page xiv)

Streptomycin Experience Pointed The Way To This New, Improved Merck Form

IT PROVIDES

(1) increased purity

(2) minimum pain on injection

(3) uniformly high potency

Now available for Streptomycin therapy is this new form—Streptomycin Merck (Calcium Chloride Complex). Developed in The Merck Research Laboratories, where pioneer work on this valuable antibacterial agent was conducted, the new, improved form of Streptomycin is recommended as an adjunct in the treatment of certain types of urinary tract infection, selected cases of tuberculosis, and other infections due to susceptible strains of gram-negative organisms.

Ask for the New
DATA CHART

This new quick-reference chart gives essential data on the clinical uses, storage, preparation of solutions, administration, and dosage of Streptomycin Merck (Calcium Chloride Complex). It will be mailed to you on request. Write to Merck & Co., Inc., Rahway, N. J.

AMERICAN MEDICAL WOMEN'S ASSOCIATION

1947-1948 BRANCH OFFICERS (continued)

THIRTY-THREE, FLORIDA

President: Laura M. Hobbs Bourne, M.D., 420 Ingraham Bldg., Miami 32, Florida.

Vice-President: Martiele Turner, M.D., 103 Douglas Entrance, Coral Gables, Fla.

Recording Secretary: Marie M. Padorr, M.D., 546 N.E. 31 St., Miami, Fla.

Corresponding Secretary: Maryland Burns Byrne, M.D., 265 S. Coconut Lane, Palm Island, Fla.

Treasurer: Rose London, M.D., 605 Lincoln Road, Miami Beach, Fla.

THIRTY-FOUR, ARKANSAS

President: Martha M. Brown, M.D., State Hospital, Little Rock.

Secretary: Alice Gamble-Beard, M.D., Little Rock.

NOTICE TO BRANCHES

Please send names and addresses of newly elected officers immediately to:

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION.

Apt. 3 — 1517 Center St.

Little Rock, Arkansas

Help keep this Directory up-to-date.

. . . to relieve the strain of

CHRONIC IRREGULARITY

WHEN aberrations of the menses suggest that normal function has overstepped the bounds of physiologic limits—the physician is often confronted with a condition which proves highly distressing to the patient. For such cases (as in amenorrhea, dysmenorrhea, menorrhagia and metrorrhagia), many physicians rely on Ergoapiol (Smith) with Savin as the product of choice. By its unique inclusion of all the alkaloids of ergot (prepared by hydroalcoholic extraction), and the presence of apiol and oil of savin—Ergoapiol (Smith) with Savin provides a balanced and sustained tonic action on the uterus, affording welcome relief in many functional catamenial disturbances. It produces a desirable hyperemia of the pelvic organs, stimulates smooth, rhythmic uterine contractions, and also serves as an efficient hemostatic and oxytocic agent. General dosage: 1 to 2 capsules 3 to 4 times daily.

Write for your copy of the new 20-page brochure "Menstrual Disorders—Their Significance and Symptomatic Treatment"
Supplied only in ethical packages of 20 capsules.

ERGOAPIOL (Smith) with SAVIN

MARTIN H. SMITH COMPANY • 150 LAFAYETTE STREET, NEW YORK 13, N. Y.

Ethical protective mark, "MHS" visible when capsule is cut in half at seam.

TAMPAX FACTS..

no. 1 It is "safe, comfortable and not prejudicial to health."[3] . . . .

In recent years, clinical investigations by prominent gynecologists have established, unequivocally, the safety, adequacy and comfort of Tampax. As stated in medicine's official journal[1], "among more than 6500 women reporting on menstrual tampons as recorded in nineteen sources in the literature, medical and commercial, there are series that voice satisfaction ranging around the 90 per cents." One comprehensive study[2] covered a total of 2,340 cases using Tampax as a menstrual guard over a five-year period. Results not only "were most favorable," but vaginal biopsies and smears showed no abnormal changes, despite twice-daily insertion of Tampax by 36 women during an entire year! It was concluded that not only are Tampax tampons comfortable, but they do not irritate vaginal tissues—do not block the flow—and do not cause cancer, erosion or vaginitis. These and many similar authoritative findings—plus the purchase of almost *2 billion* Tampax tampons by women in every walk of life during the past 14 years—are significant Tampax Facts!

TAMPAX

The internal menstrual guard of choice

REFERENCES: 1. J.A.M.A., 128: 490, 1945. 2. West. J. Obst. & Gynec., 51:150, 1943. 3. Clin. Med. & Surg., 46:327, 1939.

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Our Educational Consultants will gladly explain the Tampax Method to women's groups in nursing, schools, industry, etc., upon request. Just fill out and mail the coupon for further details.
Also available, gratis, are professional samples of the three absorbencies, Regular, Super and Junior.

TAMPAX INCORPORATED, Educational Dept.
155 East 44th Street, New York 17, N. Y.

☐ Please send further details on educational talks to women. I need material for _____ students. ☐ Send professional samples.

*Name*_____ *Institution*_____
Please Print

*Street*_____

*City*_____ *Zone*_____ *State*_____

MW-18

THE THERAPEUTIC ROLE OF VITAMINS...

. . . is more fundamental than merely to prevent or cure the well-known syndromes of specific deficiency diseases. Restoring carbohydrate and amino acid metabolism to normal is also attributable to the role of vitamins.

Recovery from shock, acute infections, and surgery is accelerated by the administration of two Gelseals 'Theracebrin' (Pan-Vitamins, Therapeutic, Lilly) per day for a week or ten days. Thereafter, one Gelseal 'Theracebrin' daily is sufficient to maintain tissue levels of the essential vitamins.

Gelseals 'Theracebrin' are available in bottles of 30, 100, and 500.

GELSEALS THERACEBRIN

ELI LILLY AND COMPANY
INDIANAPOLIS 6, INDIANA, U.S.A.

Bullous Skin Eruptions Following Sulfonamide Administration

RELATIONSHIP TO BULLOUS ERYTHEMA MULTIFORME

By Carmen C. Thomas, M.D., and Marjory K. Hardy, M.D.

From the Department of Dermatology and Syphilology of the Woman's Medical College of Pennsylvania, and the Hospital of the Woman's Medical College of Pennsylvania.

THE SYMPTOM COMPLEX of erythema multiforme bullosum is well known since its first description by Hebra in 1866 (erythema multiforme exudativum).[1] Since that time related disorders characterized by severe, sudden onset, serious constitutional symptoms, and multiple bullous and erosive lesions of the skin, the mucous membranes of the mouth, conjunctiva, and genital mucosae, with or without joint swellings, have been reported in the literature under a variety of names (Stevens-Johnson syldrome,[2] ectodermosis erosiva pluriorificialis Klauder,[3] and Behcet's syndrome[4]). Etiologic factors postulated for this entity include allergic reaction to foods, drugs, or infections, both bacterial and virus in origin. In a small percentage of cases such sequelae appear to follow the ingestion of drugs (barbiturates, phenolphthalein, sulfonamides[5,6,7,8,9,10,11,12,13,14]).

In this paper we report five cases of severe bullous erythema multiforme-like eruptions which followed sulfonamide therapy. We shall attempt to evaluate possible precipitating factors, warning signs which herald impending trouble from the drug, and include a discussion of therapeutic methods. These five patients were observed in a space of two years. All were women, ranging in age from 26 to 65 years. Three were white and two were Negroes. The eruption and symptoms in all were similarly severe and followed the administration of sulfadiazine in two and sulfathiazole in three patients.

A summary of the first and most severely affected patient, and of the last seen, whose symptoms and course were representative of the milder cases in this group, is appended. The findings in all patients are summarized in Table 1.

Fig. 1. Widespread, bullous dermatitis appearing 12 hours after a single dose of 0.25 gm. sulfathiazole. The patient had been previously sensitized by local application of sulfathiazole ointment. ***(Photograph: Collection of Dr. John H. Stokes.)***

Case 1: J. A., a 26 year old negro woman was admitted on 8-4-45 with symptoms of right upper quadrant pain, temperature of 104° F. and chills of two days' duration. She showed some right costovertebral angle tenderness. Chest x-ray, blood, sugar, and urea nitrogen were normal. She was given sulfadiazine 3 gm., followed by doses of 1 gm. four times daily from 8-5-45 to 8-18-45 with a presumptive diagnosis of pyelitis. The symptoms abated, temperature became normal, and the patient was discharged on 8-18-45. She was readmitted on 8-20-45, with a temperature of 103, a widespread dermatitis which had had its onset 24 hours previously. She had

innumerable ulcerative lesions of the lips, tongue, cheeks, and pharynx, and was able to speak only in whispers. The conjunctivae and vulvar mucous membranes showed similar extensive ulcerations. Urination was painful and difficult. The skin surface was covered by bullous and crusted lesions, sparing only the palms and soles. During the next four weeks, after a very stormy course, the patient gradually improved. The temperature became normal in 15 days. Treatment consisted of blood transfusions, penicillin over a three week period, parenteral injections of a B complex preparation, and ascorbic acid 300 mg. daily. The lesions healed with cicatricial changes in the conjunctiva, and with the formation of bands limiting eyeball motion. The erosive lip lesions healed with agglutination of the mouth angles, producing narrowing of the orifice. The urethral lesions were so severe as to produce urinary retention, necessitating catheterization. The mouth, pharyngeal, and laryngeal lesions were so painful as to make eating and swallowing almost impossible. When seen three months after her discharge, the conjunctival bands (symblepharon) were still present, and there was moderate limitation of eyeball motion, although vision was normal. The cutaneous lesions had left hyperpigmented residua.

Case 5: E. G., a 54 year old white woman, developed a bullous dermatitis of the face, V of the neck, and forearms, with injection of the conjunctivae, on 7-24-47, seven days after receiving 0.25 gm. sulfathiazole 4 times a day, given because of the presence of an inlying catheter. A perineorrhaphy and rectopexy had been performed on 4-16-47. 36 hours before the onset of the eruption the temperature began to rise, reaching 104° F. at the height of the eruption. There was no history of previous local or systemic sulfonamide administration. Benadryl, 50 mg. every 4 hours, produced prompt improvement, and in 6 days the patient had recovered.

In speculating on possible common underlying factors in this group of patients, it is perhaps of significance that in four of the patients there was either definite evidence of renal damage or of lower urinary tract infection at the time the sulfonamide was given. The factor of impaired excretion of the drug enters therefore into the picture, although this is by no means constant. In at least one patient in this group (Case 5) the total amount of sulfonamide given was so small that no explanation other than that of sensitization to the drug can explain the course of events. This has been borne out repeatedly in the literature as well as in our experience, applying particularly to patients who had had previous local or systemic sulfonamide medication. (Fig. 1 illustrates a severe eruption appearing 12 hours after administration of a single dose of 0.25 gm. sulfathiazole. This patient had been previously sensitized by the local use of sulfathiazole ointment.)

The interval of time elapsing between the first administration of the sensitizing drug and the appearance of the cutaneous reaction is usually from 7 to 14 days, which allows for the development of an allergic state. This time interval was present in four of the five patients observed. In the fifth the interval was only 4 days, a fact which strongly suggests previous exposure of the patient to a sulfonamide although this was denied by the patient.

The thought that the sulfonamide acts merely as a trigger mechanism in activating a latent virus infection has been repeatedly brought out in discussions of erythema multiforme.[10,18]

Proof will have to await more readily available virus laboratory studies, but speculation on the similarity of the mucous membrane lesions to those of herpetic stomatitis, ocular pemphigus, hoof and mouth disease, is justified. The hematologic picture in our group of cases does not help in evaluating possible virus or sensitization factors. There was neither a consistent leukopenia nor the leukocytosis which might be expected according to the severity of the temperature and the constitutional response. Likewise, no uniform changes in eosinophil or monocyte counts occurred. The fact that an elevation of temperature over the previous level may indicate impending drug intolerance has been emphasized for many years, and applies particularly to sulfonamide intolerance ("drug fever"). In every one of our patients there was a rise of 3 to 4° beginning 36 to 24 hours before the appearance of the eruption. This was frequently misinterpreted by the attending physician as indicating inadequate sulfonamide dosage, or response, and in most instances led to increase of dosage or addition of another medicament (sulfonamide or penicillin). On the withdrawal of sulfonamide a prompt remission of temperature and symptoms occurred.

Treatment: The earlier the role of sulfonamide in the production of the clinical picture is recognized and the drug withdrawn, the more rapid the recovery of the patient. The three most severely ill patients were later given penicillin therapy which appeared to aid materially in reducing at least the secondary bacterial invaders. The two patients seen within the past year were both given antihistamine drugs (benadryl) with prompt and effective relief of the skin symptoms.[16,17] Auxiliary treatment in all the patients consisted in adequate fluid intake or blood transfusion with the parenteral use of vitamin B complex preparations containing adequate amounts of niacin and riboflavin (Solu-B, Upjohn). The one patient who died did not succumb as the result of the cutaneous reaction, but died, after the skin had almost cleared, of the underlying pelvic peritonitis.

Summary

1. Case reports of 5 female patients with severe cutaneous, mucous membrane, and constitutional effects following sulfonamide therapy are presented and analyzed.

2. The factors predisposing to sulfonamide toxicity or sensitization are briefly discussed.

3. The relationship of the over-all picture to bullous erythema multiforme and a possible virus cause is considered.

4. In every instance clinical signs of drug intolerance were preceded from 36 to 24 hours by a definite elevation of temperature.

5. Treatment with the antihistamine group of drugs appears to produce rapid symptomatic improvement.

TABLE I. Summary of clinical findings of five cases of bullous sulfonamide eruption

Initial	Sex	Age	Color	Reason for giving Sulfa	Drug and daily dose	No. of days treated	Days before onset of skin lesions	Lymph node enlarg.	Severity of skin and m. m. involv.				Therapy	Outcome
									skin	conj.	mouth	vulva		
J. A.	F	26	B	pyelitis—?	sulfadiazine 3 gm.	14	15	all	xxx	xxx	xxx	xxx	Penicillin transfus. Vit. B & C	recovery—4 wks. conjunctival & urethral scarring
T. C.	F	65	W	post-op. cystitis	sulfathiazole 1 gm. sulfadiazine 12 gm.	5 2	4	ax. & cerv.	xxx	xxx	xxx	xxx	Penicillin Vit. B & C	recovery—12 days
C. B.	F	55	W	discharging ear	sulfathiazole 6 gm.	7	7	0	xx	x	xx	0	Vit. B & C	recovery—11 days
R. S.	F	27	B	pelvic abscess	sulfadiazine 6 gm.	14	14	all	xxx	xxx	xxx	xxx	Penicillin benadryl	skin much improved in 10 days. death from peritonitis
E. G.	F	54	W	post-op. prophylact. cystitis	sulfathiazole 1 gm.	7	7	0	xx	x	0	0	benadryl Vit. B	recovery—6 days.

KEY: x few lesions.
xx moderate number.
xxx profuse lesions.

Bibliography

[1]Von Hebra, F.: Diseases of the Skin. New Sydenham Society, London, Vol. 1, 1866.

[2]Stevens, A. M., and Johnson, F. C.: A new eruptive fever associated with stomatitis and ophthalmia, Am. J. Dis. Child. *24:* 526, Dec., 1922.

[3]Klauder, J. V.: Ectodermosis erosiva pluriorificialis, Arch. Derm. & Syph. *36:* 1067, Nov., 1937.

[4]Behcet, H.: Observations on clinical picture of so-called triple symptom complex, Dermatologica *81:* 73, Feb., 1940.

[5]Eichenlaub, F. J.: Erythema multiforme complicating vaccination, South. Med. J. *19:* 186, March, 1926.

[6]Anderson, N. P.: Erythema multiforme, its relation to herpes simplex, Arch. Derm. & Syph. *51:* 10, Jan., 1945.

[7]Greenberg, S. T., and Messer, A. L.: Fatal bullous dermatitis following administration of sulfadiazine, J.A.M.A. *122:* 944, July 31, 1943.

[8]Johnson, R. D.: Generalized exfoliative dermatitis (bullous) due to sulfadiazine, J. A. M. A. *124:* 979, April 1, 1944.

[9]Dardinski, V. J.: Erythema multiforme bullosum following use of sulfadiazine, Am. J. Clin. Path. *15:* 28, Jan., 1945.

[10]Fletcher, M. W., and Harris, Ruth C.: Erythema exudativum multiforme (Hebra) bullous type, J. Pediatrics, *27:* 465, Nov., 1945

[11]Costello, M. J.: Erythema multiforme bullosum following sulfonamide, Arch. Derm. & Syph. *55:* 852, June, 1947.

[12]Raffeto, J., and Nichols, S.: A nearly fatal reaction to sulfadiazine in a 10 year old girl, involving skin, eyes, and oropharynx, J. Pediatrics, *20:* 753, June, 1942.

[13]Frank, A. G., and Traub, E. F.: Varioliform eruption from sulfathiazole, Arch. Derm. & Syph. *46:* 737, Nov., 1942.

[14]Weisberg, A., and Rosen, E.: Erythema exudativum multiforme, Arch. Derm. & Syph. *53:* 99, Feb., 1946.

[15]Brainerd, D.: Erythema multiforme, J. Pediatrics, *29:* 512, Oct., 1946.

[16]Pinkus, H.: Benadryl in treatment of erythema exudativum multiforme, Ann. Allergy, *4:* 288, July, 1946.

[17]Schoenperlen, C. B.: Benadryl in the treatment of mucosal respiratory syndrome, Canadian M. A. J. *56:* 73, Jan., 1947.

Obstetrical Risks

Ann Gray Taylor, M.D., F.A.C.S.

From the Department of Obstetrics, Woman's Medical College of Pennsylvania, Philadelphia

PREGNANCY HAS BEEN DESCRIBED by some as a normal physiological process, by others as a disease of nine months' duration. Most patients fall somewhere between these two extremes. Pregnancy tests the reserves of all organs in the body. That organ with a lessened reserve which functions adequately in the non-pregnant state is apt when the strain of pregnancy is added to show up like the weakest link in a chain. Therefore, the patient must be considered as a whole, a medical as well as an obstetrical problem.

To consider the main risks individually, the one that occurs most frequently and needs the most patience in handling is hypertension. There are two main types of this complication:

1. The type which existed prior to pregnancy. It may be the result of toxemia during a previous pregnancy or of nephritis following an infection, or possibly it is the so-called essential hypertension.

2. The type which is incidental to pregnancy or signifies the beginning of a true toxemia. Of course these two overlap. A hypertensive woman who becomes pregnant is most prone to become toxic.

When a woman is seen for the first time in her seventh month of gestation, it is difficult to determine which type is present. She is usually considered a toxemia, and treated as such.

When she is seen first before the fourth month, there is a different problem. Immediately one wishes to know if she has a history of hypertension or recent acute infection. If her systolic pressure is over 160 mm. of mercury, what is the best method of treatment? Should an abortion be done or should she be carried to viability? If the heart size is normal, the electrocardiogram within normal limits, perhaps she can be carried to viability. Cesarean section and sterilization may then be performed if indicated. When treating these women, one must be prepared to interfere at any time. If the patient is not seen before the fourth month, the tendency now is against abortion, unless done by the abdominal route.

When seen for the first time after the seventh month, one must be guided in treatment by increasing albumin in urine, increasing edema, etc., to determine how long to allow pregnancy to continue. One must remember that the fetus may die in spite of treatment of the mother, and so, if carried too long, the patient may deliver a macerated infant. The second danger is abruptio placenta. I believe that any patient with marked hypertension, that is, with a diastolic pressure over 100 mm. of mercury, should be kept in the hospital. On occasions when we have allowed a clinic patient to go home, she has returned within a week definitely worse and sometimes with a true preeclampsia. The seriousness of hypertension is sometimes hard to evaluate. Then there is the patient who is definitely nephritic. If the diagnosis has not been made between pregnancies, it will become obvious with the next pregnancy. Some cases of hypertension have been reported as relieved following sympathectomy. Perhaps that will be the final answer. As yet we do not know the true cause of eclampsia or of preeclampsia. Treatment is preventive, but if hypertension occurs it is rest and sedation.

The second type of risk is the cardiac patient. About 90 per cent of these prove to have rheumatic heart disease. There seems to be a higher percentage of such cases recently, either because there are really more or because more cases are being discovered at the time of complete physical examination. These are referred to the cardiologist for classification and care throughout pregnancy. There is a high percentage of successful deliveries in these cases, particularly in Classes I and II. It is Class II which causes the most difficulty and requires careful watching during the prenatal period, delivery, and postnatal course. A patient who has never decompensated usually may be carried to term. If she ever has decompensated, she is a less good risk and may need therapeutic abortion. If decompensation occurs, it should always be treated, and the patient should be in as good condition as possible before delivery, no matter what the duration of pregnancy. Cardiac patients should be under the care of a competent cardiologist throughout pregnancy and be watched

for indication for digitalization, rest, sedation, etc.

Unless there is some other reason for it, cesarean section is not done. Fowler's position, sedation through first stage; short second stage; rest following delivery, seem to give better results.

We have been fortunate in our low incidence of tuberculosis in spite of the high percentage of negro patients. The routine x-ray of all clinic patients has not apparently increased the incidence of this complication in our clinic. The few patients we have had have done well on increased rest prenatally, short labor without inhalation anesthetic. We have not tried postpartum pneumothorax.

Patients with tumors, without marked symptoms, are usually carried to term and delivered vaginally if possible. We have removed ovarian cysts during pregnancy without interrupting the pregnancy. We find secondary anemia very common and usually give some form of iron and Vitamin B. Occasionally, if the hemoglobin is below 60 per cent, we have given blood transfusions.

If a diabetic becomes pregnant she needs to be followed carefully by a physician trained in handling diabetics, in consultation with the obstetrician. Blood sugar is to be kept constant and the patient watched carefully for signs of beginning toxemia. If it is impossible to have hormone levels determined, I do not believe in giving hormones empirically.

When acute surgical conditions develop in the pregnant woman, pregnancy is only a complication. Patients with recurrent attacks of appendicitis and cholecystitis frequently need to have operation. In our experience the infant has a 50-50 chance of surviving.

The borderline pelvis is always a problem. Whether to give a short test of labor or to do a section at the due date is always the question. Here the age of the patient and the race probably enter into the outcome more than we realize.

Since we have done routine Wassermann tests, syphilis is no longer a problem.

The Rh factor is receiving much publicity through medical and lay magazines, but we have all had contradictory results. The best rule to my mind is: Any woman under forty-five years of age should have an Rh factor determined before any blood transfusion is given.

References

[1]Beck, Alfred C.: Obstetrical practice. Baltimore, Williams & Wilkins Co., 1942, 3d ed.

[2]Dieckmann, William J.: The toxemias of pregnancy. St. Louis, C. V. Mosby Co., 1941.

[3]De Lee, Joseph B.: The principles and practice of obstetrics. Phila., W. B. Saunders Co., 1936, 6th ed.

[4]Hamilton, B. E., and Thomson, K. J.: The heart in pregnancy and the childbearing age. Boston, Little, Brown and Co., 1941.

[5]Jensen, Julius: The heart in pregnancy. St. Louis, C. V. Mosby Co., 1938.

[6]Leaman, William G.: Management of the cardiac patient. Philadelphia, J. B. Lippincott Co., 1940.

[7]Titus, Paul: The management of obstetric difficulties. St. ..ouis, C. V. Mosby Co., 1945, 3d ed.

[8]Williams, John W.: Williams Obstetrics revised by Stander, Henricus J.: New York, D. Appleton-Century Co., 1938, 8th ed.

NATIONAL RESEARCH COUNCIL GRANTS IN ENDOCRINOLOGY

The Committee on Research in Endocrinology, National Research Council, announces that requests for grants-in-aid during the fiscal year July 1, 1948 to June 30, 1949 will be received until Feb. 29, 1948. Application blanks may be obtained by addressing the Secretary, Division of Medical Sciences, National Research Council, 2101 Constitution Avenue, Washington 25, D. C. In addition to a statement of the problem and research program, the committee desires information regarding the proposed method of attack, the institutional support of the investigation and the uses to be made of the sum requested. No part of any grant may be used by the recipient for administrative expenses. The committee makes grants in aid of research in the general field of experimental and clinical endocrinology. However, applications for support of research in the problems of sex in the narrower sense cannot be given favorable consideration, and investigators who seek support in this field should direct their proposals to the Committee for Research in Problems of Sex, National Research Council.

Dr. Birch is Associate Professor of Internal Medicine, University of Illinois, Chicago

Tropical Medicine

Part XV—Platyhelminthes (continued)

CARROLL LaFLEUR BIRCH, M.D.

Hydatid Disease (continued)

When man accidentally ingests the egg it hatches in the duodenum. The hexacanth embryo burrows into the mucosa to reach a venule or lymphatic channel. It is carried over the body and screened out, chiefly in the liver, although it may pass to the lung or any other organ. In a critical location the hydatid cyst gives serious symptoms early. In the liver the cyst may become very large and symptoms may not develop for many years.

Three to four weeks after the parasite has reached its destination in the body a vacuole appears and the parasite becomes a cyst. Lining the cyst is a germinal layer of cells which gives rise to scolexes by a process of budding. A scolex in turn may develop a central vacuole lined with germinal tissue. This is called a brood capsule. Ten or more scolexes may develop within the brood capsule before it becomes detached from the lining of the original cyst. The individual scolexes which break off and float free in the cyst fluid are called hydatid sand. The cavity of the cyst is filled with hydatid fluid.

Host reaction provides the cyst with a heavy fibrous tissue capsule. Although most hydatid cysts are unilocular they may be alveolar or multilocular. The germinating layer may bud, not toward the cyst cavity, but through the capsule into host tissue and form a daughter cyst. From this granddaughter scolexes may develop. These structures are multiple and each looks like a white grape. If by chance a scolex should escape from the cyst, because of surgical interference or accident, it is capable of giving rise to a hydatid cyst wherever it may lodge. If the hydatid fluid escapes into the peritoneal cavity death may result immediately from antiphylactic reaction or later from the spread of the infection.

Early hydatid cysts of the liver are symptomless. As they grow larger subjective and objective signs of pressure become evident. If the cyst is infected it produces all of the symptoms of an abscess. Later weakness, loss of weight, and anemia appear. Cysts located in bone are painful and may result in a pathological fracture. In the lung cysts cause cough with bloody sputum and fever. Cysts in the brain may produce Jacksonian epilepsy, blindness, paralysis, or other evidence of central nervous system involvement depending upon the location of the infection.

Diagnosis is suggested by signs of a growing tumor in an individual who lives in or has visited an endemic area. A roentgenogram may be of help. If percussion elicits a hydatid thrill the diagnosis is confirmed. Eosinophilia occurs in about one fourth of the cases. Complement fixation and precipitation tests are fairly specific. Intradermal test yields an immediate reaction (within one half hour) and is a valuable diagnostic help. The antigen is the sterile hydatid fluid from the cyst of a sheep. If the cyst is in the lung the sputum may show scolexes or hooklets. Aspiration of the cyst for diagnostic purposes is contraindicated because of the danger of spreading the infection.

Prophylaxis consists of eliminating infected animals, of preventing contamination of hands, food, and water with dog excreta, and of keeping dogs from eating infected meat, and of keeping the dogs clean and burning their excreta.

The only treatment for hydatid cyst in man is surgical removal. If possible the entire cyst should be removed intact. Contamination with infective fluid can be prevented by aspirating 10 cc. of fluid and replacing it with 10 per cent formaldehyde. This kills the parasite and allows the complete removal of the cyst.

Diphyllobothriasis

Diphyllobothrium latum, or the fish tapeworm, is the causative agent. The word diphyllobothrium means two leaf-like suckers and refers to the two long grooves on the sides of the scolex which are used for attachment to the mucosa of the small intestine. Scolex and neck are followed by immature and mature proglottids. There are no true gravid proglottids, for the uterine pore which leads to the outside serves for the passage of fertilized eggs. The proglottids are wider than long and have a central rosette uterus. A complete strobile is 3 to 10 meters long and consists of about four thousand proglottids.

The ovum has a smooth shell, is broadly ovoid, and is operculated. It is unembryonated when passed. In order to survive the ovum must reach fresh water, where it matures in 10 to 20 days. Then the opercular cap opens and the ciliated hexacanth embryo emerges and swims about. The embryo is ingested by dioptimus or cyclops, loses its cilia, migrates to the hemocoele cavity, and becomes a cercoid larva. A fish eats the infected cyclops. The parasite makes its way to the muscle of the fish and becomes a second stage larva called a sparganum. When man or other mammal eats the fish the sparganum attaches to the mucosa of the small intestine and becomes an adult tapeworm. This tapeworm may live for many years. Diagnosis is made by finding the ova in the stool.

Besides man, the dog, cat, and other mammals may serve as definitive hosts. The intermediate hosts are cyclops, dioptimus, and certain fresh water fish belonging to the pike family.

The infection is limited chiefly to the North Temperate zone. It is common in northern Europe, especially in the Scandinavian countries, in Japan, in Canada, and in the United States, particularly Michigan and Minnesota.

Infection is acquired by eating raw or insufficiently cooked fish. It is quite common in Jewish housewives who taste fish dishes before they are cooked. The cycle is maintained when infected feces reach fresh water, seeding it for the cyclops and ultimately for the fish. This infection could be prevented if no sewage emptied into lakes or other bodies of fresh water.

It was long believed that this worm was the cause of a severe anemia which resembled pernicious anemia. Most workers now are of the opinion that the two conditions merely coexisted in the same individual.

Symptoms and treatment of this infection are similar to those of T. saginata.

Sparganosis

In some species of Diphyllobothrium man may serve as the intermediate host. This is true especially in the Orient, French Indo China, and Java. Sparganum mansonoides and S. proliferum are found in man. Infection may be acquired by the accidental ingestion of infected cyclops. In the Orient sparganosis is acquired by eating infected polywogs or by applying an infected split frog to an injured eye. The warmth of the body stimulates the larva to leave the frog and enter the eye, causing occular sparganosis. Tissues about the eye swell and become inflamed and painful. Larvae may penetrate the orbital fat or lodge beneath the conjunctiva causing ulceration. It may even invade the retrabulbar region resulting in lag ophthalmus. Treatment of ocular sparganosis consists of drawing the parasite to the surface by the application of heat and removing it surgically.

Sparganum proliferum buds off larvae asexually, giving rise to large numbers of spargana. Several thousands have been found in a single patient. The larvae travel from the intestine to all parts of the body and produce cyst-like nodules which contain a chylous fluid and one or more worms. In the skin they are acne-like. Occasionally they may obstruct the passage of lymph and produce elephantiasis.

Surgical removal is the only treatment.

Hymenolepiasis nana

Hymenolepis nana, or the dwarf tapeworm, is the causative agent. This is a tiny worm, 1 to 3 cm. in length, but consisting of 100 to 200 segments. The scolex has four suckers and a rostellum. The ova measure 30 to 60 micra and are almost spherical. The hexacanth embryo is surrounded by a wide clear zone and a smooth outer wall. On the inner wall of the clear zone are two polar bodies from each of which four filaments originate.

The entire life cycle is spent in a single host. When passed, the egg is infective, and superinfection from anus to mouth keeps building the infection up so that many adults are present in a single host.

Distribution of this worm is cosmopolitan. It is the most common tapeworm in Southern United States and is found in all warm moist climates of the world. It is especially common in children.

Infection with H. nana usually is symptomless. Heavy infections may cause slight abdominal distress, nervousness, and diarrhea.

Diagnosis is established by finding the characteristic ova in the stool.

As there is no intermediate host humans constitute the reservoir. Prevention is accomplished by sanitary disposal of human excreta and the establishment of hygienic habits.

There is a murine strain of H. nana which may in rare instances infect man.

Treatment. Oleoresin of Aspidium is the drug of choice. Hexylresorcinol crystoids which are fairly efficient and less toxic than aspidium can be substituted when conditions indicate.

Hymenolepiasis diminuta

H. diminuta is the rat and mouse tapeworm. Occasionally it may infect man. It is four times

the size of nana and has no rostellum. The ovum is larger but is morphologically similar except that the filaments are absent.

The adult is found in the intestine of the rat and the ova are passed in the stool. The rat flea ingests the ova and is the intermediate host. In turn the rat swallows the infected flea and completes the cycle.

Man may become infected if his food is contaminated with rat feces or he accidentally ingests an infected flea.

Dipylidiasis

Dipylidium caninum is the common dog tapeworm. Adults measure from 20 to 40 cm. The intermediate host is the dog louse or the dog or human flea. This worm is cosmopolitan in distribution.

The scolex is provided with a conical rostellum and four suckers. Each proglottid is bilaterally symmetrical and contains two sets of reproductive organs. The eggs are laid in groups of 8 to 20 within an embryonic membrane.

The cycle is simple. Proglottids adhere to the anal hair of the dog and disintegrate, liberating the ova. Ova are ingested by the flea or louse. The larval stage of the worm is passed in the insect host. The dog ingests the infected flea or louse, and the adult tapeworm develops in the dog.

Rarely man may acquire the worm by ingesting the infected dog flea or louse.

The diagnosis is established by finding the characteristic double pored proglottid in the stool.

Part XVI—Trematoda

The trematodes or flukes are classified under the platyhelminthes. They are divided into two large groups:

1. Hermaphroditic or monoecious flukes
2. Schistosomes or dioecious flukes

Hermaphroditic Flukes

In many ways a fluke resembles a single proglottid of a tapeworm. The dorsoventral flattening gives the fluke a leaflike appearance. Motility consists of wave like contractions which travel from one end of the organism to the other. The trematodes are unsegmented, bilaterally symmetrical, and covered with a thin cuticulum. At the anterior end, the oral orifice is surrounded by a sucket. A second sucker is on the ventral side. Suckers are used for attachment to the host. The digestive system consists of a mouth and an esophagus, which divides into two lateral blind ceca. The ceca may be branched or unbranched. As there is no anus, undigested food is regurgitated. The excretory system comprises two lateral collecting tubules which ultimately open externally through the excretory pore. The nervous system includes the nerve ring surrounding the esophagus and six parallel longitudinal branches. The reproductive system is highly complex and fills the remainder of the organism. There are two testes, one ovary, the oviduct complex, and a coiled uterus. Ova are stored in the uterus and discharged through the genital pore.

The ova of the hermaphroditic flukes vary greatly in size. All are operculated.

All of the flukes pass through complicated phases in their development. A generalized, simplified life cycle is composed of the following stages: From the egg the free living ciliated larva, called a miracidium, emerges. This larva penetrates the soft tissues of a snail. Two or more larval stages (sporocyst and redia) are passed in the snail. In the next larval stage, the cercariae, the parasites leave the snail and swim freely in water. The cercariae may encyst on water plants or aquatic animals. These encysted larvae are ingested by the final host where they become adult flukes and in turn give rise to ova.

Some of the more important hermaphroditic flukes which parasitize man are:

1. Fasciolopsis buski
2. Fasciola hepatica
3. Echinostoma ilocanum
4. Clonorchis sinensis
5. Heterophyes heterophyes
6. Paragonimus westermani

Fasciolopsis buski

The adult of this species is about one inch long and resides in the small intestine of man. It holds fast to the mucosa of the duodenum and causes ulceration and bleeding. Unembryonated ova are found in the stool. The egg is large, 130 by 80 micra, and has a small inconspicuous operculum. After a period of development in water the egg hatches and the ciliated miracidium seeks a plenorbid snail. In the snail the parasite passes the sporocyst and redia generations. The sporocyst is elongated and lined with germinal tissue which buds off redia. When the sporocyst is filled it ruptures liberating the redia. Each redia may in turn produce daughter redia. Within the first

or second stage redia cercariae develop. The cercariae look like tiny tadpoles with bulbous anterior portions and attenuated posterior portions. In the sunlight the cercariae swarm from the snail and swim freely in the water. Cercariae can not eat and must reach the next host within 12 to 16 hours in order to survive. Cercariae encyst on the buffalo nut, the water chestnut, or other aquatic plants. Encysted cercariae, known as metacercariae, are ingested by man. In the duodenum they excyst, attach to the mucosa, and grow to adults. Two or three months later the patient develops diarrhea and passes mucus, blood, and ova in the stool. This infection is more serious than hookworm disease. Biproducts of the worms may cause allergic reactions in the host. If the infection is heavy the growing worms may obstruct the bowel. Often secondary infection is extensive. Pigs may serve as hosts.

Infection with Fasciolopsis buski is spread by fertilizing with human night soil and eating uncooked water plants.

This infection is found in South and Central China, Formosa, French Indo China, India, and the Malay countries.

The treatment of choice is hexylresorcinal crystoids in the same manner as recommended for ascariasis.

Fasciola hepatica

This fluke is not quite so large as F. buski. It lives in the bile ducts and gall bladder of man. The ovum closely resembles that of F. buski. It passes down the bile passages to the intestine and is found in the stool. If the ovum reaches fresh water it hatches and the miracidium enters a snail. In time the cercariae leave the snail and seek the second host, which may be a water plant or crab. When ingested by a human the worm excysts in the duodenum, penetrates the wall of the intestine, crosses the peritoneal cavity to the liver, and goes through the capsule of the liver to the bile ducts.

As the parasites tear through the tissue they produce toxic biproducts and necrosis, often called "liver rot." As the flukes live in the ducts they produce hyperplasia of the bile ducts and periportal tissue and, finally, cirrhosis of the liver. Some flukes may miss the liver and pass to other tissues.

Herbiverous animals, such as sheep and cattle, may ingest the metacercariae. These animals may serve as reservoir hosts. The infection is spread when infected feces of animal or man reach fresh water.

Treatment. Intramuscular emetin hydrochloride is used in the dosage recommended for amebiasis.

Echinostoma ilocanum

This fluke is about the size of Fasciola hepatica. The adult resides in the small intestine of man. The eggs which are similar to those of fasciola are passed in the stool. The egg hatches in fresh water and the first intermediate host is a snail, the second a fish or tadpole. Symptoms and treatment are the same as for F. buski.

Clonorchis sinensis

Clonorchis is a small fluke, measuring 10 to 25 mm. Adults live in the small bile ducts at the edge of the liver. The eggs are small, about 30 micra, and have a distinct operculum that has been likened to the top of a sugar bowl. The eggs are embryonated when passed. The ova pass down the bile passages and ultimately reach the intestine and are found in the dejecta. The egg must be ingested by a snail in which it multiplies abundantly through two larval stages. In the cercareal stage the parasites leave the snail, lose their tails, and encyst under the scales and in the cutaneous tissue of fishes. Man eats the fish. The parasites travel up the ambulla of Vater and the biliary tree to the fine ducts at the margin of the liver. Passage through the liver causes great reaction. Jaundice may occur.

Treatment. Medicinal gentian violet is the recommended treatment. It is administered in the same way as for strongyloidiasis. In the early stages of clonorchiasis cure can be expected. In the late stages the worm burden can be reduced but not eradicated.

Intravenous sodium antimony tartrate is helpful also.

Heterophyes heterophyes

The adult lives in the duodenum. Ova are small, 29 by 16 micra, and are found in the stool. The proper species of snail ingests the egg. Within the snail the parasite multiplies greatly as it passes through two larval stages. Cercariae leave the snail and pass to the next host, a fish. Man, other mammals, and birds eat the fish and become infected. The parasites mature in the duodenum where they produce a mucous diarrhea. Symptoms usually are not severe.

Paragonimus westermani

P. westermani is known as the Oriental lung fluke. Adults are bullet or pea shaped and measure

8 to 20 mm. They live in the bronchioles and cause irritation which results in a productive cough with blood streaked sputum. Small dark ova are found in the sputum. To the unaided eye the ova look like a sprinkling of brown pepper. Some ova are swallowed and appear in the stool. When the ova reach fresh water they hatch and the miracidia penetrate the appropriate snails and multiply. The cercariae have rudimentary tails and are provided with stylets. They penetrate the next host, which is a crab or crayfish, and encyst in the liver or muscle. Man eats the infected crustacean. The parasites excyst in the duodenum pass through the wall of the gut, transverse the peritoneal cavity, and pierce the diaphragm to reach the pleural cavity and lung, where they become adults. Host reaction to the parasites may be chronic bronchitis, pneumonia, abscess, or the formation of fluid. Parasites may travel widely in the body. In the brain they produce epilepsy.

Treatment is unsatisfactory. Emetin hydrochloride is the drug of choice and is administered with the precautions listed under treatment of amebiasis.

Schistosoma (Blood Flukes)

The schistosomes are the most important trematodes of man. In this group of flukes the individuals exist as males and females (dioecious). They are more worm-like and less leaf-like than the monoecious flukes. Size is variable, lengths ranging from 6 to 25 mm. The females are longer and slimmer than the males. Schistosome ova are not operculated.

The word schistosome means "slit body" and refers to the deep ventral groove in the body of the male to form the gynecophoral canal. During copulation and oviposition the female lies within the gynecophoral fold of the male. Both sexes are provided with oral suckers and acetabulums, those of the male are larger and serve to anchor both worms during most of their lives. In the male the entire cuticulum may be tuberculated or spined, while in the female such structures are limited to the extreme anterior and posterior portions, those parts of the body not protected by the body of the male. The alimentary tract ends blindly. Often the gut is outlined as a reddish black structure because it contains ingested blood. The female reproductive organs consist of one ovary, yolk glands, and a uterus containing ova. The male is provided with four to nine testes.

Adult schistosomes live within the blood vessels of man, the female within the gynecophoral fold of the male. When the female is ready to oviposit the pair move against the portal blood current to the smaller vessels. As the female is slimmer she can penetrate smaller venules beyond the reach of the male. The female deposits an ovum and then withdraws a little and deposits another in bead-like formation along the course of the venule. Furthermore, she stretches the capillary and deposits eggs of greater diameter than the intact venule. When that vessel is filled the worms back into another and thus lay eggs in fan-like formation. As the ova stretch the capillary they occlude it and obstruct the flow of blood. Certain factors aid the ova in their passage through the capillary wall, pressure of the blocked blood stream, the thinned vessel wall, action of surrounding tissue, and probably a lytic secretion from the embryos within the eggs. Ultimately the ova reach the intestine or the bladder and pass out of the body in feces or urine.

To survive, the ova must reach fresh water. The eggs are embryonated when passed so they hatch soon. The liberated miracidia swim about and penetrate a snail of proper species. Within the snail host they multiply through two larval stages. In four to eight weeks forked-tail cercariae swarm from the snail during the sunlight hours.

The cercariae swim actively, tail first, until they reach the surface of the water. Some adhere to the surface film, others drop to the bottom only to swim again to the top. This vertical tour is repeated many times until they meet a host or die. Cercariae do not feed and can live only twelve to sixteen hours in a free state.

Cercariae have the power to penetrate human skin and mucous membranes. Persons drinking, bathing, wading, or washing clothes in contaminated water are apt to be infected. Barefoot farmers standing in irrigation ditches and cultivating rice fields are likely targets for infection. As the body emerges the water on the skin dries and the cercariae penetrate head first, leaving their tails outside. Within twenty-four hours some of the larvae have worked their way into the capillaries. They are carried in the blood stream through the right heart to the lung. A disproportion exists between the diameter of the parasites and that of the lung capillaries. Because the capillaries dilate and the worms stretch they finally get through to the left heart and the systemic circulation. It is believed most worms are destroyed. Only the worms which reach the portal circulation survive. Here bathed in portal blood they mature. In about three to four weeks they leave the liver and go to their sites of choice in

the body. Enroute the female is fertilized so in another few weeks oviposition begins, thus completing the cycle.

There are three important schistosomes which infect man:

1. Schistosoma mansoni
2. Schistosoma japonicum
3. Schistosoma haematobium

Morphologically these schistosomes look much alike and have similar life cycles. The symptoms they produce vary somewhat for they live in different sites in the body. Each of the schistosomes has characteristic ova.

As the cercariae of any of the schistosomes enters the skin they may cause a dermatitis with itching which lasts for several days. As the parasites pass through the lung they may produce symptoms simulating pneumonia. Ova in the tissue set up considerable irritation which may undergo malignant changes late in the disease.

Early schistosomiasis shows a leukocytosis with eosinophilia; later leukopenia and anemia are characteristic.

Schistosomiasis Mansoni

This infection is also called bilharzia. Geographical distribution includes many parts of Africa, West Indies, and South America.

The adults live primarily in the mesentery of the large bowel, although the entire intestine may be involved. Ova in the intestinal mucosa act like foreign bodies and produce irritation, inflammation, and ulceration, accompanied by fever, abdominal pain, and anorexia. There is considerable host reaction with thickening of the intestinal wall. Interference with the blood supply causes necrosis, ulceration, and sloughing which results in a fulminating dysentery with the passage of blood, mucus, and pus.

Some ova are carried back into the liver where they cause irritation and later cirrhosis. In fact ova may be carried to any organ of the body. Splenomegaly and hepatomegaly are progressive.

In the late stages the abdomen is distended, while the arms and legs are emaciated. Multiple fistulous tracts about the anus and extending from the colon sometimes are seen.

Diagnosis is confirmed by finding the characteristic ova in the stool. Ova measure about 150 by 60 micra. They are easy to identify because of the large, sharp, lateral spine.

Although this infection has been found in monkeys man is the only important mammalian reservoir host.

Schistosomiasis Japonica

As its name implies this parasite is found primarily in the Far East, Japan, China, and the Philippines, Formosa, and the Celebes.

The infection closely follows that of S. mansoni, differing from it in the following ways:

1. Man is not the only mammalian host. Domestic animals, horses, cattle, water buffaloes, dogs, and cats serve as reservoir hosts. This complicates the epidemiology.
2. The small intestine is more apt to be involved first, so enlargement of the liver and spleen occur early. In late cases the entire bowel down to the rectum is involved. Schistosomal dysentery is characteristic.
3. The ova, which are found in the stool, measure approximately 90 by 65 micra. There is a small lateral incurved spine.

Schistosomiasis Haematobium

This disease has several synonyms, urinary bilharzia, endemic hematuria, etc. It is found primarily in Africa and the Middle East. It differs from S. mansoni in the following ways:

1. Adults inhabit the vesical venules, and egg laying produces changes in the bladder wall. Terminal painless hematuria often is the first symptom. Later urination becomes painful.
2. Late in the disease the rectum and large bowel may be involved.
3. Characteristic ova are found in the urine and late in the dejecta as well.
4. The ova measure 150 by 60 micra and have large terminal spines.

Treatment

Fuadin (neoantimosan) is the drug of choice, given intramuscularly. A 7 per cent solution is used. On the first day 1.5 cc. is given, the second day 3.5 cc., the third day 5 cc. After this 5 cc. are given every other day for seven injections. The total dose is 3.15 gr.

Other drugs may be used such as anthiomaline, potassium antimony tartrate, and sodium antimony tartrate.

In the early stages schistosomiasis responds well to treatment.

Prophylaxis

Prevent fecal contamination of water by proper hygiene, sanitation, and sewage disposal. This will prevent the infection of snails.

Get rid of the snails by the use of copper sulfate.

Avoid drinking, bathing, wading, or washing in infected water. This is very difficult to accomplish for a slight exposure may lead to infection. If one foot or hand slips into a contaminated pond infection is likely to follow. Riding a horse through an infected, irrigated field, the water being splashed up on the legs by the horse's hoofs, is a likely source of infection.

Laboratory infections are common. Touching the water on a slide containing cercariae, or the splash from filling an aquarium may lead to infection.

Schistosomiasis is a serious condition which gravely affects morbidity and mortality in endemic areas.

Acanthocephala

At times the Acanthocephala are included in the phylum nemathelminthes. More often they are placed in a separate category.

In the Acanthocephala, or spiny-headed worm, the sexes are separate. Both males and females have probosces which are armed with spines and are retractile. The body is cylindrical and lacks a body cavity and a digestive tract.

The Acanthocephala have complicated life cycles involving alternation of hosts. Alternation occurs between insects and mammals.

Only two of these worms are parasites of man:

1. Macracanthorhynchus hirudinaceus infects hogs, wild boars, peccaries, and rarely dogs and cats. Man is an accidental host. The intermediate host is an insect of the beetle family.

Man acquires the parasite by accidentally ingesting the infected larval beetle. The adult worms are large; the female measures from 200 to 650 mm., the male from 50 to 100 mm., they inhabit the gastro-intestinal tract, causing diarrhea and eosinophilia.

2. Moniliformis moniliformis is the only other member of this group which infects man. This worm is creamy white and measures 100 to 270 mm. The usual definitive hosts are rats, mice, hamsters, dogs, and cats. Man is an accidental host. Intermediate hosts are beetles and cockroaches. The symptoms produced in man are abdominal pain, diarrhea, and eosinophilia.

So far as man is concerned the Acanthocephala are unimportant, for they parasitize man rarely.

The Leeches

Leeches have soft, segmented bodies with anterior and posterior suckers. Located in the anterior sucker is the mouth, which sometimes is provided with teeth. Leeches suck blood painlessly. They attach by the anterior suckers, and break the skin with their teeth or by suction and action of a proteolytic enzyme. An anticoagulant, called hirudin, is secreted, which causes the blood to flow easily. When the animal is engorged it drops from the host leaving a weeping ugly lesion which heals slowly. Secondary infection is common.

There are two kinds of leeches, aquatic and terrestrial. Aquatic leeches have a wide geographic distribution in the fresh waters of the world. They attach themselves to the skin of bathers for a blood meal or they may be taken into the body in unfiltered drinking water. From the oral cavity they may migrate to the pharynx, trachea, or bronchi, attach to the mucous membrane, engorge with blood, and mechanically obstruct the passage of air. If they reach the stomach they are digested.

Terrestrial leeches are found in moist tropical areas of South America and the Far East, in Malaya, Burma, Assam, and some islands of the South Pacific. They are most common in the rainy season. These leeches reach their host by hanging from grasses or leaves along overhanging trails. Others climb from the ground up the leg beneath the trousers to the skin.

As the bites of these worms are painless their presence may not be observed. If the infection is heavy the first symptom may be weakness from loss of blood.

Treatment. Mosquito repellents such as 612 and dimethyl phthalate are very effective prophylactically. An attached leech can be removed by applying salt, vinegar, cocaine, or almost any strong solution. A lighted match or cigarette placed near the posterior end of the leech will cause it to dislodge. Bleeding is controlled by a styptic pencil and a sterile dressing applied. If the leech is in the pharynx the patient's head should be placed in a dependent position. Application of a solution of cocaine or strong saline will cause the leech to dislodge and fall where it can be reached with forceps.

Bibliography

Ashford, B. K. and Igaravidez, P. G.: Uncinariasis in Porto Rico. U. S. Senate Document No. 808, 1911.

Bachman, G. W.: Report of Director, Sch. Trop. Med. Univ. Puerto Rico, 1938.

Brockett, S.: Schistosome Dermatitis (1) J.A.M.A. *113*, 117, 1939; (2) Arch. Derma. and Syph. *42*, 410, 1940; (3) J. Parasitol. *26*, 195, 140; (4) Am. J. Hyg. *31*, 64, 1940 & 32, 85, 1940.

Chandler, A. C.: Introduction to Parasitology. London 1940.

Craig, C. F., and Faust, E. C.: Clinical Parasitology 1945.

Dammin, G. J.: Trichinosis. N. E. J. Med. *224,* 357, 1941.

D'Antoni, J. S., and Sawitz, W.: Treatment of Oxyuriasis. Am. J. Trop. Med. *20,* 377, 1940.

Faust, E. C., et al: Comparative Efficiency of Various Techniques for Diagnosis of Protozoa and Helminths in Feces. J. Parasitol. *25,* 241, 1939.

Faust, E. C., and DeGroat, A.: Internal Auto-Infection in Human Strongyloidiasis. Am. J. Trop. Med. *20,* 1940.

Foster, A. O., and Lansberg, J. W.: Nature and Cause of Hookworm Anemia. Am. J. Hyg. *20,* 259, 1934.

Hall, M. C.: Studies on Trichinosis. Pub. Health Rep. *53,* 1472, 1938. Carbon Tetrachloride for the Removal of Parasitic Worms. J. Agr. Res. *21,* 157, 1921.

Hinman, E. H.: Clinical Aspects of Strongyloides Stercoralis Infection. Rev. Gastro-Enterol. *5,* 24, 1938. Filarial Periodicity. J. Trop. Med. Hyg. Sept. 1, 1937.

Lane, C.: Hookworm Diagnosis. Trans. Roy. Soc. Trop. Med. Hyg. *33,* 521, 1940.

Faust, E. C., et al: Lecture Notes from course in Tropical Medicine, Tulane University.

Mackie, Col. T. T.: A Manual of Tropical Medicine. 1945.

Mueller, J. F.: Studies on Sparganum Mansonoides and S. Proliferum. Am. J. Trop. Med. *18,* 303, 1938.

Scott, R. B.: Iron Deficiency Anemias. Lancet *549,* 1938.

Strong, Richard P.: Stitt's Diagnosis, Prevention, and Treatment of Tropical Diseases. 1942.

Swartzwelder, J. C.: Comparison of Five Laboratory Techniques for the Demonstration of Intestinal Parasites. J. Trop. Med. Hyg. *42,* 185, 1939.

Ward, H. B.: Introduction and Spread of the Fish Tapeworm in the U. S. DeLamar Lectures. 1929-1930 Balto., 1930.

Wright, W. H.: Studies on Trichinosis, XI. Am. J. Pub. Health. *29,* 119, 1939.

LONGEVITY OF AMERICAN PHYSICIANS*

THE expectation of life for physicians in the United States is essentially the same as that for the general white population at the same ages, according to a study by the Metropolitan Life Insurance Company based upon the records of deaths among active and retired physicians in the files of the American Medical Association. The study covered the five-year period, 1938 to 1942, inclusive. The average male physician entering his profession at age 25 has 43½ years of life before him. This represents roughly the average professional career of a physician under current conditions of mortality. Upon reaching age 35, he still has, on the average, almost as many years remaining as he has already lived. At age 45, the average physician may expect to live an additional quarter century, and at 65, often regarded as retirement age, he may still look forward to almost 12 years of life. Women physicians start out with an advantage of 3½ years over the men at age 25, but this margin is reduced to less than 1½ years by age 65.

At the younger ages, physicians have a slightly greater expectation of life than white persons in the general population; at age 25 physicians have the better outlook by about one quarter of a year. However, this small advantage is lost even before mid-life is reached. From age 35 onward, the prospective lifetime for physicians is somewhat less than that for white persons in the general population, but the differences are not significant.

The foregoing figures for expectation of life relate only to males, who constituted 96 percent of the profession under study.

Compared with white males of the same ages in the general population, the entire body of male physicians at all ages 25 and over have the greater death rate by 2 percent. However, marked differences become evident for specific age periods. At ages 25 to 34, for example, the death rate for male physicians is only three fifths of that for white males of the same ages. This advantage of physicians wears off rapidly with advance in age. At ages 55 to 64, physicians have the higher rate by 11 percent, and at ages 65 to 74 by 5 percent. The death rates for the physicians and the general population are practically identical at ages 75 and over.

—From *Statistical Bulletin,* Metropolitan Life Insurance Company, August 1947.

*This article is based upon the paper, "Longevity and Mortality of American Physicians, 1938-1942," by Louis I. Dublin and Mortimer Spiegelman, Journal of the American Medical Association, Vol. 134, page 1211, August 9, 1947.

Recent Advances in Pediatrics

May Borquist Guy, M.D.

DEVELOPMENTAL PEDIATRICS. Gesell and his Yale group have rendered enormous contributions to pediatrics by their observations on growth and development of children from a scientific "laboratory" standpoint and by assembling this data into a field of clinical medicine called "Developmental Pediatrics."[2] Development as well as disease falls within the province of clinical pediatrics; in fact the concepts of development and disease cannot be divorced. Malnutrition may lead to maldevelopment; the severity and incidence of disease are influenced by age and maturity. In health and disease the child will be more and more appraised in terms of his growth characteristics and developmental status.[3,4,5]

Growth phenomena are predictable, following a regular pattern and sequence, and indicated most sensitively by the child's behavior. Thus the average normal full term baby may be expected to smile at 1 month of age, have some head control at 3 months, roll from back to abdomen at 5 months, and use prehensile grasp at 8 months.[1] These facts enable the pediatrician to demonstrate to the mother what progress the child will make next and to advise her to make use of each ability as it appears rather than oppose it. Conversely the futility of expecting the infant to acquire control such as bowel and bladder before he is mature enough has a direct bearing on his mental health. Application of the Gesell norms of development by periodic observations are helpful in determining mental status and suitability for adoption.

The child's ways of growth and development have much bearing on his feeding behavior. Thus feeding problems are minimized when more attention is paid to the infant's demands than to a clock work schedule. Infants put on a self-regulating regime showed desire for feeding intervals of less than 4 hours in the first two months of life. Then only gradually they approached the average recommended by physicians and at the age of one year had good appetites and compared favorably in height and weight with accepted standards.[6] Anorexia in preschool children continues to be one of the most frequent complaints for which they are brought to the pediatrician. The most common etiological factor is lack of understanding of the physiological anorexia of the second year. The child needs less food and at this age no single food is essential to his well-being.[7]

IMMUNIZATION. Advances made in the past decade include continual improvement of antigens, dosage, and timing.[8]

Smallpox vaccination has become pretty much standardized, but recent threatened epidemics have brought forth some antiquated procedures and practices which have been condemned by public health authorities. Vaccination should be done on the arm, by the multiple pressure method, and not covered by any bandage or shield. Calf lymph virus remains the best vaccine. Vaccination may be performed at any time during the first year of life and repeated at school age and during the threat of an epidemic.[8]

Pertussis. The present practice of waiting until 6 to 8 months to immunize the infant is criticized because it leaves unprotected the age group which is most seriously affected by the disease.[9] In the past it was believed that adequate antibody response was not obtained at an earlier age. However, recently improved methods of measuring the immune response of infants have demonstrated the effectiveness of beginning as early as 6 weeks.[10,11] Alum precipitated vaccine appears to be superior to plain vaccine for this purpose. Immunization of mothers against pertussis during the last trimester of pregnancy has been shown to confer early passive protection on the newborn and young infant.[12] Vaccine used for pertussis immunization should be made up of whole bacteria in the antigenic Phase I.[9,12] Other forms (Endo-Antigen, Endotoxoid) are not of proved prophylactic value. For basic immunization at

least 70 billion bacteria should be used; for boosters 1 year later and at school age, 20 billion each. A skin test (Flosdorf test) has been devised for testing for immunity to pertussis.

Pertussis vaccine is not so potent an antigen as diphtheria and tetanus toxids. Nevertheless it protects 2 out of 3 intimately exposed children and 4 out of 5 less intimately exposed, and the disease occurring in immunized children is less severe. Apparent failure to protect may also be due to parapertussis as the causative organsim.[8]

Diphtheria. Basic immunization around 6 to 8 months seems satisfactory at present, using 2 injections of alum toxoid or 3 of the plain toxoid. The plain toxoid in smaller doses is better for older age groups. Schick tests may be done three months after basic immunization and again at school age; some prefer routinely to give a booster instead. Miller points out that the Schick test also acts as a small booster.[8]

Tetanus. There is some argument concerning the necessity of giving routine tetanus immunization, at least in cities. It should be given to the child who lives in the country or spends summers there or who tends to frequent trauma. It is easily combined with diptheria toxoid and pertussis vaccine. Alum precipated toxoid is considered superior for basic immunization. Miller recommends boosters every two years. Where a booster is given at the time of a wound, fluid toxoid should be used and antitoxin also given if the wound is a fulminating one. The fact that lesions leading to tetanus infection are often trivial and overlooked emphasizes the importance of a constant immunity.[8]

Combinations of triple vaccines reduce the number of injections necessary and give satisfactory results with the possible exception that the optimum amount of pertussis vaccine may not be given. This can be corrected by giving extra pertussis vaccine inoculations preferably at an early age.

Scarlet fever immunization is effective but its routine use is precluded by severe reactions.

Typhoid immunization is determined by geographical considerations.[8]

Measles. There is no active immunization against measles but it can be prevented by temporary passive immunization with gamma globulin, the portion of the plasma in which antibodies are concentrated. Its chief use is in protecting the very young and debilitated. It can be used in older children in appropriate doses to allow "modified" measles and thus confer lasting immunity.[14]

Diseases of the Newborn Period. *Epidemic diarrhea* is the most serious infection of the newborn period and the dread of newborn nurseries. Virus etiology is suspected. Cleanliness, careful techniques, control of infection among personnel and mothers, and visitor control are important in prevention. Isolation, maintenance of fluid and electrolyte balance are important in the treatment. As to the most important of these, Katherine Dodd makes the statement "I have never seen a serious epidemic develop in a nursery where babies were carefully watched by pediatricians even though physical facilities except for plenty of soap and water for handwashing were poor."[9,10]

Syphilis presents great diagnostic difficulties in the newborn, clinical signs and symptoms rarely being present at birth. If an infant has syphilis it is better to treat before symptoms and signs do appear. In the days of prolonged treatment it was usual to wait for a definite positive diagnosis. With the advent of penicillin treatment is advised if there is a 50 per cent chance of infection (considering age of infection of mother and amount of treatment). Quantitative tests are valuable in following results of treatment.[11]

Erythroblastosis fetalis or congenital hemolytic disease of the newborn occurs in about 1 out of every 250 to 300 babies. It results most frequently in the Rh positive offspring of Rh positive fathers and Rh negative mothers. The mechanism is an antigen-antibody reaction, the mother becoming "immunized" to the Rh positive factor of the fetus and producing antibodies which in turn are transmitted to the fetus and cause hemolysis of the red blood cells. About 1 in 25 infants of such matings develop the disease. The first born is hardly ever affected. Another cause is the repeated transfusion of an Rh negative patient with Rh positive blood which may lead to transfusion reactions or to hemolytic disease in later offspring of females so treated. No Rh negative girl or woman should ever be transfused with Rh positive blood. The administration of Rh positive blood even in childhood may prevent normal childbearing later.

Recent knowledge since 1944 shows that the Rh factor is not a single entity but composed of several fractions, that these occur in the red blood cells of all white races, and that each produces a specific antibody. Their arrangement on chromosomes is postulated, Rh positive being a mendelian dominant and Rh negative a recessive character. Laboratory tests have been devised and perfected for detection of various types and

also for testing the titer of antibodies in the expectant mother's blood.

The old terms (a) fetal hydrops, (b) icterus gravis and (c) anemia of the newborn, correspond in general with (a) extreme, (b) severe to moderate, and (c) mild forms of the disease. The first condition is almost invariably fatal, as a stillbirth or early infant death. The most dreaded complication in surviving infants is kernicterus in which portions of the brain are deeply jaundiced and mental defectiveness results.

Treatment consists principally of transfusions with Rh negative blood, endeavoring to keep the infant's red blood cell count above 3 million and the hemoglobin above 10 grams. These babies should not be breast fed because anti-bodies may be present in the mother's milk.[27,28]

CONGENITAL DEFECTS. *Etiology.* Virus diseases occurring in the prenatal period may play a role in the etiology of congenital defects. Mothers having rubella, especially during the first trimester of pregnancy have given birth to a fairly large proportion of infants with defects, principally of the eye lens and heart. Measles, mumps, varicella, herpes, and scarlet fever have also occurred in mothers who later had defective offspring. Data so far, however, is insufficient to conclude what to do in event of the occurrence of rubella or other contagious disease in pregnancy.[29,30]

Surgical Correction. Surgery on congenital defects of heart and great vessels constitutes a brilliant advance in pediatrics. Cases of persistent ductus arteriosus, pulmonic stenosis and atresia, and double aortic arch have been successfully relieved. Fluoroscopic and x-ray studies of cases to determine suitability for surgery have stimulated greater knowledge in this field and a closer working together of roentgenologist, clinicians, and surgeons.

Robert Gross, Alfred Blalock, and H. A. Potts are the pioneers in this highly specialized type of surgery. The Blalock operation[22] for pulmonic stenosis and atresia in Tetralogy of Fallot creates an artificial ductus by anastomosis of an innominate or subclavian artery to the pulmonary artery. The Potts modification consists of securing the pulmonary artery to the side of the aorta and opening a communicating window between the two. Gross operates on uncomplicated persistent ductus arteriosus where it is not a compensatory mechansim for other heart lesions.[23]

Double aortic arch is a syndrome that was recognized in 1837 and remained of academic interest only until successful surgical treatment by Gross in 1945. The typical symptoms are respiratory stridor, dyspnea aggravated by feeding and lying prone, cyanosis since birth, and frequent head retraction. Some cases have been confused with enlarged thymus and irradiated without success.[23,24]

Congential atresia of the bile ducts was also regarded as a pathological curiosity not amenable to therapy until Ladd and Gross devised an operation which is suitable for about 20 per cent of the cases, remnants of the bile ducts being anastomosed to adjacent portions of the gastro-intestinal tract.[25,26]

NEW SYNDROMES. *Fibrocystic disease of the pancreas* has been described most extensively by Dorothy Andersen.[27,28,29] It is characterized by the onset in the early months of life of frequent respiratory infections and failure to gain in spite of good appetite. Pancreatic secretion is low in enzymic ferment and the resulting stool contains increased fat. There is a loss of fat soluble vitamins A and D. Avitaminosis A plays a part in lung changes and lowered resistance to respiratory infections which do not respond to ordinary treatment. Duodenal drainage with analysis of enzymes is helpful in diagnosis.[30] This familial syndrome is now being recognized with increased frequency. The prognosis has improved considerably with adequate and early treatment of respiratory symptoms with sulfonamides and antibiotics and of gastro-intestinal symptoms with high protein, high vitamin, low fat diet.

Waterhouse-Friderichsen Syndrome. This is a fulminating purpura associated with adrenal hemorrhage and a blood stream infection, frequently meningococcal. Age incidence in children is from 2 month to 2 years.[31] Onset is usually very rapid in a previously healthy child with high fever, purpura, hemorrhagic rash, and signs of collapse. Death may occur in 24 to 48 hours. Treatment must be immediate with sulfonamides, penicillin, parenteral fluids, and adrenal cortical extract.

Subdural Hematoma in Infancy was not recorded adequately until 1944, when Ingraham and Matson[32] described a series of cases and stated that it is a fairly common condition during the first two years. It is a source of high morbidity and mental defect if neglected. It is usually caused by trauma to the head and treatment is fundamentally neurosurgical.

Salicylate Intoxication in children is more frequently due to overdosage of aspirin than to accidental ingestion. Infants are more prone to it than older persons. The picture is that of a severe prolonged acidosis, resistant to ordinary treat-

ment. Warning is needed on this drug, similar to that on sulfonamides.[82]

NEWER DRUGS AND ANTIBIOTICS. Many of the benefits from new drugs and antibiotics are the same as for adults. This discussion will be limited to a few outstanding applications in pediatrics.

Meningitis occurs most frequently during the first two and a half years of life, most common forms being tuberculous and meningococcic types. Pneumococcus, influenzal, streptococcus, staphylococcus, and colon bacillus meningitis also occur.[83] In general, meningitis due to H. influenzae and E. coli respond better to sulfonamides than to penicillin, whereas pneumococcus responds somewhat better to penicillin.[36,37] However, in all severe forms of bacterial meningitis it is safer to use the combined treatment. Intrathecal administration of penicillin sometimes gives reactions but is usually used anyway in treating a severe disease such as pneumococcus meningitis, where sequelae are so damaging.

Streptomycin is a valuable addition to the treatment of influenzal meningitis and is combined with serum and sulfonamides when the disease is severe. Streptomycin has also had some benefit in tuberculous meningitis, otherwise 100 per cent fatal.[42]

Sulfonamides. Toxicity was found low in a group of 200 children where mixtures of sulfonamides were used (sulfathiazole and sulfadiazine, sulfadiazine and sulfamerazine),[34] the simultaneous solution of both giving higher blood levels with less tendency to precipitation in the urinary tract than when one was used alone.

Sulfonamides have been found useful as prophylaxis against recurrence of rheumatic fever. Although they are without benefit in active rheumatic fever and may even cause exaggeration of symptoms, small doses are successful in the quiescent rheumatic stage in preventing the occurrence of hemolytic streptococcus infections. The reactions are few but require close observation of the patient to prevent and control. One gram in one or two daily doses is given the year around.[39,59,60]

Penicillin. In congenital syphilis penicillin is a satisfactory treatment and has almost supplanted arsenic and bismuth therapy.[42]

In subacute bacterial endocarditis penicillin gives better results in children, possibly because the endothelial lesions are less extensive than in adults. Large dosage is required.[42]

The development of the single dose, slowly absorbed penicillin in oil, maintaining adequate blood level for 24 hours or more, is of much practical value in treatment of children. Occasionally local reactions occur after ten days but these are not severe.

Streptomycin. It is too early for full evaluation of this antibiotic, especially in tuberculosis. It will probably be most useful as an adjuvant in the treatment of early forms of tuberculosis. Permanent benefit in meningeal or miliary forms is somewhat doubtful and the organism frequently develops resistance to it.[42]

It is the best treatment available for mild or moderately severe meningitis due to the influenza bacillus (for very severe cases it is combined with sulfonamides and serum) and several other commonly encountered gram-negative organisms. Opinion is divided on the safety of giving it intrathecally.

It is indicated in infections caused by gram-negative bacteria and in many heretofore resistant infections of the urinary tract, for which it is more effective when the urine is alkalinized. Organisms should be tested for their sensitivity to streptomycin and many quickly develop resistance to it.

In pertussis, aerosol treatments with streptomycin have shown some good results.

Streptomycin is said to cause more neurological toxic effects if the treatment is prolonged over two weeks or if the average dose is greater than 1 gram daily, or if given intrathecally.

Anti-Convulsants in Epilepsy. Because epilepsy is very prevalent among children and youths the newer agents in treatment are a boon to pediatricians. Dilantin and the newer product mesantoin help in control of grand mal. Tridione and its newer ethyl derivative, (not yet on the market) are effective for petit mal. To be able to control the periods of "blacking out" which these children undergo immensely improves their social outlook and progress at school. Unfavorable reactions must be watched for in all of them although the newer derivatives show less toxicity.[44]

BIBLIOGRAPHY

[1]Aldrich, C. A., and Norval, M. A., A developmental graph for the first year of life, J. Pediat, 29:304, Sept. '46.

[2]Gesell, A., Developmental pediatrics, J. Pediat. 30:88, Feb. '47.

[3]Gesell, A., and Armatruda, C. S., Developmental Diagnosis, Paul B. Hoeber Inc. 1941.

[4]Gesell, A., The First Five Years of Life, Harper and Bros., 1940.

[5]Gesell, A., and Ilg, F., The Child from Five to Ten, Harper and Bros., 1946.

[6]Aldrich, C. A., and Hewitt, Edith, Feeding program for infants, J.A.M.A., 135:340, '47.

[7]Bakwin, R. M., Feeding difficulties in early childhood, M. Clin. North America, May '47, p. 688.

[8]Miller, J. J., Immunization procedures, J.A.M.A., 134:1064, July 26, '47.

[9]Cohen, P., Active immunization in pediatrics, M. Clin. North America, May '47, p. 590.

[10]Waddell, W. W., and L'Engle, C. S., Immune response to early administration of pertussis vaccine, J. Pediat, 29:487, Oct. '46.

[11]Sako, W., Studies on pertussis immunization, J. Pediat. 30:28, Jan. '47.

[12]Sauer, L. J., Whooping cough: prevention and treatment, M. Clin. North America, 30:45-59, Jan. '46.

[13]Cohen, P., and Scadron, S. J., The effects of active immunization of the mother upon the offspring, J. Pediat. 29:609, Nov. '46.

[14]Greenberg, M., Gamma globulin in pediatrics, M. Clin. North America, May '47, p. 590.

[15]Round Table Discussion on Infections in the Newborn Period, J. Pediat. 30:696, June '47.

[16]Standards and Recommendations for Hospital Care of Newborn Infants, Children's Bur. Publ. No. 292.

[17]Potter, Edith L., Rh: Its Relation to Congenital Hemolytic Disease and to Intragroup Transfusion Reactions, Year Book Publishers Inc., 1947.

[18]Potter, Edith L., Advances in clinical medicine, M. Clin. North America, Jan., 1947, p. 236.

[19]Swan, C., and Tostevin, A. L., Congenital abnormalities in infants following infectious diseases during pregnancy with special reference to rubella, M. J. Australia 1:645-649, May 11, '46.

[20]Conte, W. R., McCammon, C. S., and Christie, A., Congenital defects following maternal rubella, Am. J. Dis. Child., 70:301-306, Nov.-Dec., '45.

[21]Gross, R. E., Persistent ductus arteriosus and its surgical treatment, Advances in Pediatrics, Vol. I, p. 167, '42.

[22]Taussig, H. B., The surgical treatment of pulmonary stenosis and atresia, Bull. of Kings County Med. Soc., Oct. 30, '46.

[23]Gordon, Susanna, Double aortic arch, J. Pediat. 30:428, Apr. '47.

[24]Sweet, R. H., Findlay, C. W., and Regersback, G. C., The diagnosis and treatment of tracheal and esophageal obstructions due to congenital vascular ring. J. Pediat. 30: 1, Jan. '47.

[25]Ladd, W. E., and Gross, R. E., Abdominal Surgery in Infancy and Childhood, W. B. Saunders & Co., Phila. 1941.

[26]Case Reports of Children's Memorial Hospital; Jaundice, 5:647, Sept. '46.

[27]Andersen, D. H., Pancreatic enzymes in duodenal juice in celiac syndrome, Am. J. Dis. Child., 63:643-658, Apr. '42.

[28]di Sant 'Agnese, P. F. A., and Andersen, D. H., Fibrocystic diseases of pancreas, IV, Chemotherapy, Am. J. Dis. Child., 72:17-61, July '46.

[29]Andersen, D. H., and Hodges, R. G., Genetics of cystic fibrosis of pancreas, Am. J. Dis. Child, 72:62-80, July '46.

[30]Rosenfeld, G. B., and Baxter, W. J., Fibrocystic disease of pancreas in infants, Canad. M.A.J., 54:438-441, May '46.

[31]Case Reports of Children's Memorial Hospital, Case No. 263, 3:27, Feb. '44.

[32]Ingraham, F. D., and Matson, D. D., Subdural hematoma in infancy, J. Pediat. 24:1-37, Jan. '44. correction, 24:221, Feb. '44.

[33]Erganian, J. R., Forbes, G. B., and Case, D. M., Salicylate intoxication in the infant and young child., J. Pediat. 30:129, Feb. '47.

[34]Lehr, D., Slobody L., and Greenberg, W., Uses of Sulfadiazine, sulfathiazole, mixture in treatment of children, J. Pediat. 29:275, Sept. '46.

[35]Levinson, A., Meningitis, Brenneman, Practice of Pediatrics, IV:8:1. W. F. Prior and Co., Inc.

[36]Ross, J., and Burke, F. G., Pneumococcus meningitis in infants and children: A report on use of combined sulfonamide and penicillin therapy, J. Pediat. 29:737, Dec. '46.

[37]Levinson, A., and Earlywine, J., Pneumoccic meningitis in children, Arch. Pediat. 64:285, June '47.

[38]De Sanctis, A. G., and Pittings, G. E., Rheumatic fever and sulfanilamide, Advances in Pediatrics, 1:290, Interscience Publishers, Inc. 1942.

[39]Wolf, R. E., Rauh, L. W., and Lyon, R. A., Prevention of rheumatic recurrences in children by use of sulfathiazole and sulfadiazine, J. Pediat. 27:516-520, Dec. '45.

[40]Baldwin, Janet S., Sulfadiazine prophylaxis in children and adolescents with inactive rheumatic fever, J. Pediat. 30:284, Mar. '47.

[41]Rose, E. K., and György, P., Penicillin in treatment of syphilitic infection, J. Pediat. 29:567, Nov. '46.

[42]Lyon, R. A., Use of penicillin in treatment of subacute bacterial endocarditis in children, J. Pediat. 29:560, Nov. '46.

[43]Ehrlich, J., Streptomycin: A Review, J. Pediat. 30:541. May '47.

[44]Lennox, Wm. G., Newer agents in treatment of epilepsy, J. Pediat. 29:356, Sept. '46.

INTERNATIONAL SECTION

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

Prof. A. Ch. Ruys, *President*
Hanthorstratt 50, Amsterdam Z,
The Netherlands.

Dr. Doris Odlum, *Hon. Treasurer*
56 Wimpole St.,
London, W.1., England.

Dr. G. Montreil-Straus, *Hon. Secretary*
75 rue de l' Assomption,
Paris, xvl, France.

A Message from the President of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

It is with great pleasure that I accept the invitation of the Editors of the Journal of the American Medical Women's Association to send a New Year's greeting to its readers.

Years ago, when passing a large workers' meeting in France, I saw a banner with the inscription: Pour tout le monde le travail, la joie, et l'amour! I was struck by the deep meaning of these words. In my opinion they express the three essentials of a happy life. If one of these three—work, joy, or love in its widest sense—be missing, life is incomplete.

Therefore, I should like to send to all of you this wish, which contains the three essentials for an harmonious life. May the New Year bring us nearer to a happier future!

A. Charlotte Ruys, M.D.

DR. RUYS

THE WORLD MEDICAL ASSOCIATION

Report of the First Annual Meeting

The W. M. A. was founded at the International Medical Conference convened in London on September 25 to 27, 1946, by the Medical International Professional Association and the British Medical Association. Its first annual meeting was held in Paris on September 16 to 21, 1947, under the chairmanship of Prof. Eugene Marquis. Delegates from fifty countries were present. The M. W. I. A. was represented by Dr. Odlum, from London, and Dr. Montreuil-Straus, from Paris. UNESCO was represented by Dr. Zhukova. It is to be noted that these three observers were the only medical women present.

The aim of the W. M. A. is to establish close relations between the National Medical Organizations and the doctors of all countries by personal contacts or by any other possible means, to maintain the honor of the medical profession and to protect its interests, to study and expose problems of professional order which claim the attention of the medical profession in different countries, to establish relations with the W. H. O. UNESCO, and other similar organizations so as to convey to them the views of the medical body, and finally to help the peoples to attain a sanitary standard as high as possible. We recall that these aims are very similar to those of our

M. W. I. A. Because of this the discussion of the various amendments which were made in the draft articles and By-Laws during the first part of the meeting were especially interesting for us.

Two questions were on the program: War crimes committed by doctors, and Medical organizations and the State. For lack of time, only the first question could be studied. As we believe that this subject is of a special interest for medical women, we give here the resolutions adopted after the remarkable discussion of Dr. Charles Richet, professor at the Faculty of Medicine of Paris, and member of the Academie de Medecine, who had been deported.

I. That a report on crimes committed since 1933 by doctors and medical organizations, in Germany and other countries, and on this violation of medical ethics be prepared and made available to doctors throughout the world. (Danish proposal)

II. That the W. M. A. solemnly condemn the crimes against human beings committed by certain members of the medical profession, such as are described in the British memorandum. (British proposal)

III. That every doctor, at the time of receiving his medical degree or diploma, be required to subscribe to the following oath "My first duty, above all other duties, written or unwritten, shall be to care to the best of my ability for any person who is entrusted or entrusts himself to me, to respect his moral liberty, to resist any ill-treatment that may be inflicted on him, and in this connection to refuse my consent to any authority that requires me to ill-treat him. Whether my patient be my friend or my enemy, even in time of war or in internal disturbances, and whatever may be his opinions, his race, his party, his social class, his country, or his religion, my treatment and my respect for his human dignity will be unaffected by such factors." (French proposal)

IV. That the W. M. A. endorse judicial action by which members of the medical profession who shared in war crimes are punished.

V. That the W. M. A. request the German medical syndicates to make the following public declaration:

a) We, members of the German medical syndicates, are aware of the very large number of acts of cruelty committed, both by individuals and collectively, since 1933, in mental hospitals and in concentration camps, and of the violation of the medical ethics. These acts have resulted in the deaths of some millions of people. A large number of our members have been implicated in these acts, either as instigators or as technical agents or as actual perpetrators.

b) We regret that the organized medical profession in Germany has not made any protest and has been content to ignore these acts, of which it could not have been unaware;

c) We undertake solemnly to condemn these crimes, to expel from our organization the criminals who have committed them, and to remind all our members of the respect due, not only to life, but to human personality, dignity, and liberty.

During the discussion concerning these resolutions, Dr. Odlum spoke in the name of the M. W. I. A. to point out that at the M. W. I. A. Congress in Amsterdam, the proceedings had concluded with adoption of a resolution stating that medical women must not only qualify themselves as individuals in the best tradition in all branches of their profession, but also participate effectively in the moral betterment of society at local, national, and international levels, and that this resolution gave a general agreement to the resolution adopted by the W. M. A.

Reported by Dr. Doris Odlum
and Dr. Montreuil-Straus

THE PRE-WAR GERMAN MEDICAL WOMEN'S ASSOCIATION

Esther Pohl Lovejoy, M.D.

The interesting article by Dr. Gabriele Strecker regarding medical women in Germany which appeared in the November issue of the Journal recalls my visit to Berlin, en route to Russia, in 1923, and the organization of the German Medical Women's Association.

At that time I was president of the Medical Women's International Association and watched with deep interest the growth of the German society. In spite of the difficulties mentioned by Dr. Strecker remarkable progress was made by that association as compared with national organizations of women doctors in other countries.

Within a few years the membership of the German society in the M.W.I.A. was second only to that of Great Britain, and larger than that of the United States which was organized in 1915. Of the twenty-two national societies which constituted the international body in the early thirties only three published periodicals—the British, American, and German.

The nature and extent of the interests and activities of the German association were indicated in articles and reports which appeared from time to time in its own publication and in the Medical Women's International Journal. Dr. Elise Hermann of Hamburg was the corresponding secretary of the German branch of the M.W.I.A. in 1930. The following information is quoted from her report which appeared in the December issue of the Medical Women's International Journal:

"The Federation of German Medical Women consists of about 750 members . . . The chief function of the Federation during the last year consisted in trying above all to unite the German medical women. The principal aim of the Federation, trying to obtain influence on social-hygienic politics, was checked by hindrances, as the economical depression prevented the development of social politics at public expense for social-hygienic aims. Nevertheless our Federation tried to have influence at least upon the reform of everything concerning midwives not yet uniformly regulated by the German legislation. Members of our Federation were instructed to work out a law concerning midwives the outline of which was put before the Reichstag and other important Government organs.

"Other branches which interest our Federation are of a professional nature, as for instance the question of married women in official places. Owing to a restriction in public expenses some authorities do not employ married women. The standpoint of our Federation is that such measures are not admissible for women only, especially as this is in contradiction with the German constitution.

"The economical situation of medical women in Germany at present is as hard as that of their male colleagues, due to the fact that, although there is an increase of the number of panel (insurance) patients, it takes a long time to be admitted as a panel doctor, so that medical women just starting have to put up a very great fight, as do their male colleagues, to build up their practice . . . Therefore, the chief aim of our Federation is not only to improve the economical position, but especially to solve questions of general interest together with the Association of German University Women and the Association of German Women's Federations."

Two years later, December, 1932, an inspiring report of progress, written by Dr. Hoffa of Berlin, the President of the German Medical Women's Association, was published in the Medical Women's International Journal. This contained a detailed account of medico-social activities in the local branches and in the national association including efforts to influence legislation in the interests of married women physicians. The membership had increased to 877 members, made up of 25 local groups and 99 individuals.

Measured in its effects upon mankind it is a long time since those reports were written. World War II has been fought and the German Medical Women's Association dissolved in the general dissolution. But order may be coming out of chaos. It is heartening to learn through Dr. Strecker's article of the formation of the Association of the Medical Women of Wuerttemberg-Baden in 1945 which was licensed by the Military Government in 1947. The purposes of this association: the promotion of the economic interests of medical women (including opposition to discrimination against married women physicians) and the participation in problems of vital interest to the welfare of the country in co-operation with other groups of women with similar objectives, seem identical with the activated purposes of the German Medical Women's Association in 1930 and 1932 as officially stated above.

The readiness of the medical women of Wuerttemberg-Baden to organize immediately after the War which ended in Germany in May, 1945, seems to indicate that they had not forgotten the old association. And similar activities among women physicians in Bavaria, Hanover, Hamburg, and other parts of Germany are reminiscent of the rapid growth of the German Medical Women's Association in the ninteen-twenties and early thirties. This will be a hard generation in Germany, but those of us who remember the pre-war groups of medical women in that country have faith that the post-war groups will more than measure up to their opportunities.

INTERNATIONAL INTERLUDE

(Continued from December)

(Lack of space has prevented our printing these interesting accounts in earlier numbers. More will follow in subsequent issues—Editor)

A visit to foreign states and conversations with colleagues of other nations are of interest if for no other reason than that they stimulate discussions and clarify points poorly understood. The Congress of the Medical Women's International Association in Amsterdam afforded many of us not only a visit to Holland and the interchange of ideas with some 350 colleagues from many countries, but also visits to other foreign countries. I visited Denmark and Sweden in addition to Holland.

In evaluating a health program for any country it is necessary to remember that areas, population, and languages play a big role. The United States with its large areas and its many regions of sparse population presents a very different problem from the more densely populated European countries. By way of reminder, Texas is approximately the size of France; Sweden compares in size with California; Holland somewhat with Maryland; and Denmark could be set down between San Francsico and Los Angeles and still have plenty of elbow room. A population of 100,000 in an urban community offers a problem very different from the same number of people scattered over an area as large as the State of Nevada.

In summarizing impressions gleaned from a short visit to these countries it seems feasible to contrast types of medical problems, therapy, buildings and equipment, and organization.

Medical Problems

In visiting a pediatric hospital or pediatric division of a general hospital one encounters the usual case that is seen at home. These "interesting cases" such as Hodgkin's disease, hydrocephalus, and blood dyscrasias are diagnosed and treated about the same the world over. Unfortunately also rather universally these cases furnish much of the teaching material, the basis for research, and the sources for medical articles. During the war a British psychiatrist made a statement to the effect that if all interesting cases were to die in one night it would cause scarcely a ripple on the fate of the universe. How true this statement is and yet how preoccupied physicians remain with the interesting case, often to the neglect of the general health problems that are of grave concern to successful survival of free men!

The war years had a marked effect on some general health problems. However, the situation was kept surprisingly well in hand during the war and except where diseases existed prior to the war either there was not a marked increase or as soon as the war was over conditions were quickly under control again. There was an epidemic of diphtheria which caused a high mortality partly because antitoxin was not available in adequate amounts for proper therapy. In other countries extensive immunization programs were put on as emergency measures and the number of cases of diphtheria actually decreased. Tuberculosis statistics indicate a marked increase of this disease in the European countries, as might be expected with crowding and poor nutrition during the war years. Venereal diseases also increased and there has been difficulty in some instances in getting penicillin for therapy. Even during the war years, because of special care and rations, maternal and infant mortality showed no marked increase. Nutritional disturbances are still occurring which are hard to explain but probably are due to some type of deficiency. Some doctors felt that there was "a hidden hunger" from lack of vitamins. There was an increase in hepatitis in one of the countries visited. My trip did not take me into the more devastated areas. The northern countries are frugal, honest and have a good morale, all of which aid materially in maintaining or restoring good public health.

Therapy

Physicians in these countries feel that the war years have left them very far behind in regard to therapy. However, a visitor did not find this to be true. It was gratifying to find that one could speak as easily about the new drugs and new methods of therapy with these colleagues as with the members of the profession at home. It does not take very long to get the essentials of therapy of a new drug or biotic. Much of the ground work that had to be done could be merely accepted, thus giving the late arrivals the advantage of starting on a firm basis, whereas we had to live through the period of experimentation and often learn by trial and error. Immunization to pertussis and tetanus is not so generally practiced as in our country, but BCG is used much more extensively since the tuberculosis problem is far greater than in the United States. The emphasis on tuberculosis and dermatology (including syphilology) is quite conspicuous. Psychiatry and health education, on the other hand, are lagging behind this work in our own country.

Buildings and Equipment

In general the Northern European countries have well built and well equipped hospitals and other institutions for the care of the infirm and aged. An old folks home which we visited had private rooms for both men and women as well as married couples. It was decidely "co-educational" even to sponsoring weddings between octogenarians. In one wing was a large infirmary where those with temporary or prolonged illnesses could receive adequate care. A doctor visited three times a week and more often as indicated. Even the name, "Sunshine Home", shows an advancement beyond the traditional names such as "home for incurables", "poor house", and the like. This is a need that has been largely unmet in our country.

On the other hand, an unrestrained building program may be carried to extremes. One hospital had an entrance hall on the admitting floor that suggested space prepared for a Grand Central station. The floor below this had a similar hall around which were such institutions as two day nurseries, one for children of visiting patients and one for the helpers' children. There was a cafeteria, a news stand, a flower stand, and a snack bar. One had the impression there might even be a surplus of elevators. A pamphlet on a recently completed and opened children's hospital in one of the other countries indicated a hospital so modern and up-to-date that I doubt that there is any hospital in my own community which has such complete equipment. One inevitably feels that there is an inconsistency between this type of expenditure for hospital and equipment on one hand and the marked restrictions

on food, clothing, heat, and comfort of the individual on the other. The question arises whether or not money might not be used to greater advantage for clothing, food, and recreation on a family basis than for elaborate institutions for the care of the sick at a "state" level.

Organization

There are certain characteristics that impress a visitor on first impact. In the general hospitals, for instance, the divisions of medicine, surgery, and radiology were repeatedly emphasized. The obstetrical department was never mentioned. On inquiry it was learned that pathological obstetrics is usually admitted to surgery. Many deliveries are still done at home and others are done in special obstetrical small hospitals or nursing homes. Midwives take care of a great number of deliveries.

The Department of Radiology often comprised one floor or one whole wing and sometimes even two floors. Emphasis was placed on diagnostic x-ray and therapeutic x-ray. Again inquiry revealed that a high percentage of the therapy cases are treated for arthritis. Inevitably the question arises as to whether or not money expended for heat, food, rest, and recreation at the family level might not reasonably lessen arthritis more effectively than equipment for elaborate therapy.

The orthopedic and physical therapy departments assumed a more rightful proportion of space than is usually given to them in our hospitals. A gymnasium with the necessary equipment for exercises of all kinds and a swimming pool nearby was inviting to one interested in the restoration of function to limbs crippled by poliomyelitis or by accidents in an industrial era.

In some of the places private practice has dwindled to insignificance. Health measures are set up about as follows: Urban communities have one or more general hospitals and special hospitals as indicated by the population. The rural communities are divided into regions corresponding roughly or in a similar manner to our counties and these have county hospitals organized very much like urban hospitals. The staffs of these hospitals are what we would term full time physicians and "closed". In other words, the chief of a service such as pediatrics has an assistant and other physicians in positions of limited tenure comparable to our interns, residents, and fellowships. The chief of the service and his assistants are on a full time basis and are permitted to do a very limited amount of private practice, mostly consultation work. The physicians doing private practice stated that most of their practice was on an insurance basis. The greatest difference in this work from our own is that physicians in private or insurance practice must send their patients when hospitalization is necessary to the closed staff of the hospital. Although this may give the patient as good, maybe sometimes better, specialized care than he would get if his personal physician took care of him through his hospitalization period, it has a detrimental effect on the practicing physician and eventually dulls diagnostic acumen. On the other hand, a full time hospital practice decreases inevitably the humanitarianism developed by intimate family contact and the individual responsibility for the care of the patient. The widespread "free" hospitalization has also had the inevitable result of many patients hospitalized for "social reasons". A home that is without heat, dark much of the year, and severely limited on food rations is an excellent incentive for psychosomatic symptoms.

Specialization is accomplished in a somewhat different manner than in our country. Usually the specialist must have a certain number of years as assistant to the chief of the service before he is given credit as a specialist. These positions are limited and therefore appointment is not entirely dependent upon the ability of the physician to qualify as specialist. In our own setup specialization is open to all of us who wish to qualify and is granted by examination. Certainly our system is far more elastic, is far more stimulating and if the responsibility of freedom is fully assumed it has far greater possibilities for creating not only the highest type of medical care of the ill but also for stimulating a desire for positive health. Even a day's journey by train through the countryside where the farmer tilled his soil, produced his own fruits and vegetables and cereals, and had his own animals for meat and other by-products, impressed one with the importance of the individual and the family unit and its independence as contrasted with the instability and intangibility of the "state". However, free men must assume responsibility, practice individual integrity, and concern themselves with the care of less fortunate fellowmen if freedom is to survive. Unless private practice of medicine teaches and practices these responsibilities diligently it will not survive.

—H. E. Thelander, M.D.

INTERNATIONAL CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS DUBLIN, JULY 7 TO 11, 1947

Reported by Eva F. Dodge, M.D.

The International Congress of Obstetricians and Gynecologists was held at Dublin, in celebration of the Bi-centenary of the Rotunda Hospital.

The scientific sessions were divided into five groups, one subject being taken up each day. In the morning sessions formal papers were given by three or four professors from different countries. In the afternoon sessions three or four others opened the discussion, and each day ample opportunity was given for general discussion. The afternoon sessions were quite lively ones. The subjects discussed were: Puerperal Sepsis, Eclampsia, Shock in Obstetrics, Sterility, and Fetal and Neonatal Mortality.

At the opening session, President O'Kelley of Eire greeted the more than five hundred physicians from thirty countries who were in attendance.

A short history of midwifery was given. In Ireland untrained midwives are known as "handy women or wives." In 1700, these women called in physicians merely for moral support, as most of the physicians then knew no more than the handy women themselves. Bartholomew Mosse, in 1745, finally opened a small hospital for maternity cases only. He used all means possible to raise the money for it and established the present system of Masters. A theater and entertainment hall was built at one corner of the hospital plant, the proceeds of which go toward the maintenance of the hospital. The fact that the original buildings are still usable is a tribute to a great man's vision and his refusal to use any but the best of materials, despite the fact that he never had money enough ahead to do more than pay the current bills.

The Rotunda Committee planned a most interesting series of social affairs. On the first night there was a reception at the Royal College of Physicians, given by the President of the College, Dr. Bethel Solomons. The second evening His Excellency the President of Eire held a reception at the "White House" of the country. This building set in a beautiful park amid lovely gardens is modeled after our own White House. An Irish Regimental Band in full regalia furnished music. The refreshments at both functions were delicious and plentiful. The third afternoon was left free from scientific meetings in order that the members of the Congress might attend The Master's Garden Party at the Rotunda Hospital. Everyone hoped that the continuous showers of the previous few days would hold off for the garden party, and though the sun did not shine, at least the rain did desist for those hours. The halls of the hospital as well as the gardens were open and many of the Congress made use of the opportunity to visit the hospital itself.

On Wednesday evening the Medical Association of Eire held a reception and on the following evening the Congress dinner for visiting physicians was given. On the last evening the well known Abbey Theater Players gave a gala performance for the Congress.

While few new ideas were put forth at this Congress, it was felt by many that good would come from the chance to pool our knowledge and from the propounding of the things we need to work on for the future. Stress was put on preventive measures for toxemia, though no one had any new ideas as to the cause. While puerperal sepsis is still present, relaxation from known protective measures must never be allowed. More thought must be given to the elimination of infectious factors. Most speakers felt that "obstetric shock" was not the correct expression, as shock is the same in obstetrics as in other conditions and is not primarily obstetric. Rather one should say "shock in obstetrics". No new concepts of cause or treatment were brought out, though again a plea was made for the use of all possible means to prevent the occurrence of shock. Apparently the same conditions exist in other countries as in the United States regarding fetal and neonatal mortality. There has been reduction in the rates in all but the first week of life. The need for conservative care as well as for more trained nursing care of the premature infant was emphasized.

Of the five hundred physicians attending the Congress, at least fifty were women, including those from China, India, and Australia, as well as from the Continent and the United States, and several participated in the discussions.

THE FOURTH INTERNATIONAL CANCER RESEARCH CONGRESS ST. LOUIS, SEPTEMBER, 1947

Reported by Dr. Georgiana Bonser, Leeds, England, Vice-President, British Medical Women's Federation

The Fourth International Cancer Research Congress, arranged under the auspices of the Union Internationale Contre le Cancer, and the American Association for Cancer Research, took place in St. Louis, Missouri, early in September, 1947. To those who came from Europe the choice of place seemed a little unusual—so far West and so remote from other medical centres. But this old town on the banks of the Mississippi, with its English and French speaking University centres and its famous Cancer Research Departments proved to be an admirable meeting place, not least for the foreign delegates. Compelled as they were to travel 1,000 miles west, the opportunity then arose to visit centres other than those situated near the Eastern seaboard, a profitable experience which might otherwise have been missed. The choice of time was happy, in that most American workers were about to return to their laboratories following the long vacation, so that the visitors were able to plan their subsequent personal visits and to find most departments in full work again. As far as the heat was concerned, the choice of time was not quite so happy, for the thermometer reached or exceeded 90° every day.

The gathering was a very representative one, with more than 1,000 delegates from forty or so countries. At the first official banquet, a message of welcome was read from President Truman and the announcement was made that it was his intention to liberate under controlled conditions radio-isotopes for use in research centres throughout the world. For those countries in which it is unlikely that the preparation of these substances will be possible for a long time to come, this was good news indeed.

The scientific proceedings were divded into general and special sections, the former consisting of long papers given by invitation and the latter of short papers, followed by discussion. As is always the case in such large gatherings, there was much overlapping of sections and as no one can be in two places at once, it was often necessary to miss papers which it was desired to hear. The proceedings will, however, be published in full. Far too much last-minute alteration of the programme was allowed, so that papers were often missed on account of ignorance of when they were to be given.

Looking back, the most striking feature was the demonstration of the great progress which has been made in this field since the last full Congress held in Brussels in 1936 (the Third Congress held at Atlantic City in 1939 was partly disrupted by the outbreak of war in Europe). New discoveries, for example the demonstration of the milk factor in mice, have been made and new methods of approach have been instituted, for example the use of radio-active substances and the electron microscope. Perhaps the most fundamental advance has been the demonstration that the malignant change is due to an interplay of a number of factors rather than to any one single factor. This in itself may render the discovery of the ultimate cause of cancer more difficult but at least it has opened up enormous new fields for investigation.

The contribution of women to the Congress and to the whole field of research in cancer is no mean one, yet not one woman was invited to speak at a general session nor at an official banquet. There

was no woman chairman or vice-chairman of a session. These omissions seem to the European unworthy of the great democratic ideals of America.

It is needless to say that the greatest value of large Congresses of this kind lies in the personal contacts which are made and in the opportunities for friendly discussion of common problems. The lobby outside the lecture rooms was invaluable in this respect, for there, cooled to some extent by bottles of the American national drinks dispensed free of charge *ad libitum* came and went a perpetual stream of those who did not wish to listen to papers but were ready to talk and there also was the display of scientific exhibits, with their appropriate demonstrators. In addition, there were the social functions arranged by the Women's Committee. It would be quite impossible to express what the Congress owed to the work of this Committee. Cocktail and tea parties, dinners, an open air concert and endless private hospitality were provided with the utmost generosity.

It is heartening, in a difficult and troubled world facing an uncertain future, to have had the experience of being one of a large gathering charged with such enthusiasm for the work in hand. The problem of cancer is a most baffling one; thirty years of intensive work in centres all over the world have gone into it and many well-known workers are already dead; yet one leaves the Congress with an impression of hope and confidence. The end, if not in sight, is at least around the corner.

"MESSAGE FROM A FOREIGN VISITING DOCTOR"

Dear Doctor:

I have spent about eight months in these United States of America, and now, on the eve of my departure for my own country, I wanted to tell you what I think of your country.

I am so impressed with the hospitality, the assistance and the respect accorded me by all hospitals I visited, such as the Presbyterian Hospital, Mount Sinai, the Woman's Hospital, the New York Infirmary, Bellevue, and many others, where I have been received and where I learned so much in the short period of my stay here. I have visited many countries, but what I saw in New York cannot be compared with anything in the world. I consider the progress in scientific research and social work in America at the highest level. I was gratified to find that any doctor, without any discrimination as to color, nationality, or age, has an opportunity to learn as much as he desires, and that visiting doctors are treated and respected equally with the American citizens.

After staying in New York for this short period of time, I wish to thank all the doctors at the hospitals whom I had the pleasure of meeting. I am carrying away wonderful memories and hope that I shall be able to apply, at least some of the methods observed, in my work in my own country, and shall always be dreaming of returning here some day, welcomed by the Academy of Medicine.

All my best wishes to American Doctors and to New York, which is a real Medical Center of the World.

Sincerely,
Dr. Mariam Fahimi

Oct. 22, 1947

Teheran
Iran

Give Them This Day . . .

The campaign of American Overseas Aid and the United Nations Appeal for Children conducted in February offers the people of the United States the privilege to demonstrate democracy through generous and voluntary gifts of money and to express intimate concern for the welfare of their fellowmen around the world today, and that they are solidly behind their government in its official program of assistance.

Relief of the distressed has always been a matter of American concern. In our local communities, private welfare agencies, supported by voluntary contributions, were effective in succoring needy neighbors long before the concept of public assistance became established. Similarly, a number of private American agencies, many of them representing our great religious denominations, have been carrying on works of mercy and friendship in foreign lands for generations.

The hospital in China which grew under the tender care of an American missionary . . . the nursery in France established during the terrifying days of World War I . . . the orphanage in Greece built as a direct result of American gifts . . . the religious organization-supported dental clinic in the Philippines . . . these are monuments to friendship which agencies united under the AOA-UNAC banner have built in the years gone by.

Today's needs are as critical as yesterday's; today's problems are infinitely greater. By supporting this urgent campaign, the people of the United States can give the world further proof that our democracy is keenly alert to the welfare of the world's people; proof that it is both productive and strong enough to translate concern into concrete and effective assistance.

Supplementing, as it does, governmental aid, and providing a personal link between each American and his fellowman overseas, AOA-UNAC is an indispensable stone in the arch of peace and understanding which we are resolved shall be fashioned. It is, as President Truman recently said at the White House, "essential to the program which is now in the making for the welfare of the whole world."

Contributions should be turned over to local AOA-UNAC committees or mailed directly to American Overseas Aid-United Nations Appeal for Children, 39 Broadway, New York 6, N. Y.

EDITORIAL

WE ARE PROUD TO announce that during 1947, the second year since the JOURNAL was founded, it has grown in stature and importance.

A questionnaire was circulated among the members of the Association and our subscribers in an effort to learn what particular features were approved and what new departments should be added. We welcome suggestions and constructive criticism.

The paper shortage was one of the great difficulties to contend with in the early days but this condition is gradually improving and we hope to increase the page volume in the near future. The number of advertisers is increasing with each issue as we become more firmly established among scientific periodicals. We are extremely grateful to Dr. Schrack, Chairman of the Publication Committee, and to Mrs. Mercer, our Advertising and Business Manager, in securing advertisers. We also wish to express our thanks to members of the Association who have brought the JOURNAL to the attention of prospective advertisers.

When the idea of this JOURNAL was projected, it was felt that there was a real need for a monthly publication which would keep the members of the American Medical Women's Association informed of its various activities, and also present original scientific articles, case reports of special interest, historical reviews, and the most recent advances in medicine. These would give a cross section of the accomplishments of women in medicine and therefore would be of special value to all of us. We are steadfastly adhering to this purpose and the expansion of the field to include women in other countries is a natural growth.

Our sincere appreciation is extended to Dr. Reid and Dr. Atkinson, Assistant Editors, for their unselfish and invaluable aid in developing new departments and for their vision in creating and establishing a general expansion program for the future.

For the coming year the Editors look forward to greater accomplishments. They must repeat again the message of the previous year: That success is possible only through the help and whole-hearted support and co-operation of the members of the Association. For this is the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION and each one of you shares a responsibility in its future.

❧ ❧ ❧

Because of limitations of space imposed on the JOURNAL *through paper shortage and other factors, it was impossible to include in one issue all of the excellent material submitted for the October number, which was devoted to the Woman's Medical College of Philadelphia. Two of the papers omitted from that number are printed in this issue. Others will follow as space permits. The Editors express their thanks to these contributors for their understanding and consideration and especially to Dr. Carmen C. Thomas through whose effort the material was collected. The Woman's Medical College is to be congratulated on the high quality of the contributions made by its staff and the* JOURNAL *on having been selected as the medium of publication.*

❧ ❧ ❧

The Mid Year meeting of the Board of Directors, Regional Directors, Chairmen of Committees, etc., was held in Cincinnati, December 5 and 6, Dr. Gardner, presiding. A full report will appear in the February issue of the JOURNAL.

ORGANIZATION

Official Reports and Announcements of the Association

COMMITTEES

NEW LIFE MEMBERS

231—**Caridad Emiliana Gonzalez, M.D.,** 8304 Harford Road, Baltimore 14, Md. M.D., University of Havana, Cuba, 1944. Member County Medical. Specialty: Pediatrics and General Medicine.

232—**Elisabeth Martin, M.D.,** 756 Cypree Street, North East, Atlanta, Ga. (Already member.)

233—**Martha Welpton, M.D.,** 814 Devon Ct., San Diego, Calif. (Already member.)

234—**Lillian Bullock Mahan, M.D.,** 7710 El Cajon Blvd. La Mesa, Calif. (Already member.)

235—**Cordelia Koch Dowman, M.D.,** 3162 Peachtree Dr., North East, Atlanta, Ga. (Already member.)

236—**Carrie Ethelyn Chapman, M.D.,** Mayo Clinic, Rochester, Minnesota. (Already member.)

NEW ACTIVE MEMBERS

CALIFORNIA

Florence Olive Austin, M.D., 1302 Centinela, West Los Angeles 25, Calif. M.D., Rush, Chicago, Ill., 1919. Fellow, AMA; member, County and State Medical; American Psychiatric Association. Specialty: Psychiatry, numerology, and mental hygiene. Endorsed by Drs. Gertrude C. Seabolt and Margaret Farr Hara, M.D.

Pauline Odessa Roberts, M.D., 2192 West 26th Place, Los Angeles 7, Calif. M.D., University of Illinois, 1943. Specialty: Public Health. Endorsed by Drs. Gertrude C. Seabolt and Stella B. Sorolser.

GEORGIA

Katrine Rawls, M.D., Sylvania, Ga. M.D., University of Ga., 1940. Member of AMA, County Medical. Endorsed by Drs. Estella McNiece and Amey Chappell.

ILLINOIS

Julie E. Olentine, M.D., 3812 West Monroe Street, Chicago 24, Illinois. M.D., Rush Medical College, 1940. Member of County Medical. Specialty: Obstetrics and Gynecology.

KANSAS

Agnes L. Robbins, M.D., R.N., 1720 Central Avenue, Kansas City, Kansas. M.D., University of Kansas Medical School, 1944. Member County Medical. Specialty: Pediatrics.

LOUISIANA

M. Goorwich, M.D., 1934 Peniston Street, New Orleans 15, La. M.D., Tulane, 1922. Member of AMA, County Medical, I.A.R.S. Specialty: Anesthesia.

Gloria Weir, M.D., 6200 La Salle, Box 11, Baton Rouge, La. M.D., Louisiana State University, 1943. Member of AMA, County, and State Medical. General Practice. Endorsed by Drs. Adele Simmons and Lucy S. Hill.

MISSISSIPPI

Maria S. Mangold, M.D., 729 Fifth Street, Yazoo City, Miss. M.D., University of Vienna, 1940. Member of AMA, County Medical. Specialty: Pediatrics. Endorsed by Estelle Magiera, M.D.

Clara M. Erdelyi, M.D., Health Department, Canton, Miss. M.D., University of Budapest, 1937. Member County Medical. Endorsed by Estelle Magiera, M.D., and Mary Riggs Noble, M.D.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

APPLICATION FOR MEMBERSHIP

☐ Active. $5.00 ☐ Associate. No dues ☐ Life $100. ($50 in two payments)

(Active, associate, and life members receive the official publication. Active and life members receive membership in Medical Women's International Association.)

Dr. .....

(Please print name as you wish it to appear in Year Book)

Address .....

.....

Medical School ..... Year of Graduation .....

Other Degrees .....

Licensed in County ..... State .....

Member County Society — Yes ☐ No ☐ Fellow A. M. A. — Yes ☐ No ☐

Specialty ..... Specialty Board — Yes ☐ No ☐

Place of birth—City ..... State ..... Single; Married; Widow .....

Date of Application ..... Signature .....

Endorsed by *(No endorsers necessary if applicant is a member of a County or State Medical Society)*

1 ..... M.D., Member AMWA

2 ..... M.D., Member AMWA

NOTE: Make check payable to American Medical Women's Association, Inc.

Mail this blank and check to Treasurer, MARY RIGGS NOBLE, M.D., Bowmansdale, Pennsylvania

NORTH CAROLINA

Annie Louise Wilkerson, M.D., 201-204 Woodard Bldg., Raleigh, N. C. M.D., Medical College of Virginia, 1938. Member of AMA, Raleigh Academy of Medicine, County Medical. Specialty: Obstetrics and Gynecology. Endorsed by Elisabeth Martin, M.D., and Amey Chappell, M.D.

NEW YORK

Emma Selkin Aronson, M.D., 57 West 57 Street, New York, N. Y. M.D., Woman's Medical College of Pa., 1910. Member of AMA, County Medical, F.A.C.S. Specialty: Surgery, Gynecology, Obstetrics. Endorsed by Emily Barringer, M.D., and Elaine Ralli, M.D.

PUERTO RICO

Jean Crowley Antonmattei, M.D., Box 104, Guayanilla, P. R. M.D., Marquette University, 1944. Member of AMA, County Medical. Specialty: Public Health. Endorsed by Drs. Dolores M. Pinero, and Blanca A. Lhiberes.

Josefina Villafane de Martinez, M.D., Ponce de Leon 1312, Santurce, P. R. M.D., Woman's Medical College of Pennsylvania, 1911. Member of AMA. Specialty: Gynecology. Endorsed by Drs. Dolores M. Pinero and Blanca A. Lhiberes.

Catalina Searano, M.D., Luna 47, Ponce, P. R. M.D., Medical College of Virginia, 1939. Member of AMA. Specialty: Pediatrics. Endorsed by Drs. Dolores M. Pinero and Blanca A. Lhiberes.

NEW ASSOCIATE MEMBERS

NEBRASKA

Betty Hall Kane, 3417 Dodge, Omaha, Neb. M.D., University of Nebraska, 1948. Endorsed by Drs. Aileen E. Mathiasen and Elinor E. Marsh.

Virginia Mae Stuerner, 327 North 37 Street, Omaha 3, Neb. M.D., University of Nebraska, April 10, 1948. Endorsed by Drs. Aileen E. Mathiasen and Elinor E. Marsh.

Opportunities for Medical Women

AN ASSOCIATION OF MEDICAL WOMEN:

Opportunities for Service

Extracts from the address by the President, DR. ELAINE P. RALLI, *at a dinner meeting on November 12, 1947, of the Women's Medical Association of New York City.*

It gives me the greatest pleasure to greet you this evening. I know that you join me in welcoming our guests.

* * *

I have said to you before and I say again, that I think there are unusual opportunities ahead of us. I wish to make it perfectly clear just what I visualize as the purposes of the Women's Medical Association of New York City, and I am particularly pleased that the Presidents of the Medical Societies of the State and County of New York and the President of the New York Academy of Medicine are with us, so that they may know the reasons for an association such as ours. Perhaps it would be wise if I were to state at the outset that this Association does not imply the isolation of women from men physicians. Quite the contrary. Every one of our members is a member of the County and State Medical Societies, and we know that those societies will develop and protect the opportunities for physicians, regardless of sex. The Academy of Medicine provides for all doctors in New York and its vicinity magnificent opportunities for keeping abreast with medical science. What then, one may ask, is the reason for an association such as ours, and in what way can it contribute to the development of medicine? I am glad that the reasons for the origin of this Association have almost been dissipated. The antagonisms that faced the woman physician fifty years ago are almost a thing of the past. There are excellent opportunities in medicine for women today. I do not mean to say that there are not certain reservations in the minds of some institutions concerning the woman doctor, nor do I mean to say that every woman physician can get the exact opportunity that she desires, but I would like to point out that the same situation operates in the case of many of our male colleagues. Naturally, where we can help to correct inequalities in the opportunities available to women physicians we will do so, but I repeat that happily such instances are few and far between and would hardly constitute a reason for an association.

There are many services that an Association such as this can accomplish. To point out one way that we can be of service I must digress a moment and refer to a situation that you as thinking physicians are well aware of, namely, the disorganization in Europe, which makes it almost impossible for the European countries to rehabilitate and re-educate their professional groups rapidly enough to meet their needs. In contrast, we in this country have not had our institutions physically destroyed, and although our physical equipment seems inadequate to us, to the physician or scientist from the cities of Europe it seems magnificent. This has resulted in making this country, and particularly this city, the medical center of the world. Men as well as women physicians are making every effort to get to this country in order not only to learn of the advances that have been made in medicine, but also to get fundamental training. Certain agencies are doing a good job, but here is one of our very real opportunities as an association. Our headquarters can serve as an Information Bureau for women doctors and help provide them with information about existing opportunities. This hotel in which our headquarters are situated will make every effort to give them accommodations. The mechanics of such a service should not be difficult to work out, particularly with the United Nations at our doorstep. The fact that there are five medical schools in this city makes our problem easier. Several of these institutions are providing graduate courses for physicians of all countries, and in many instances our work will be to acquaint physicians of the existing facilities.

Our second opportunity as an Association is a community one. We are all aware of the extraordinary difficulties facing the hospitals, both private and city, today. As an organization we can reinforce the policies of the County and State Societies, and in fact we may even ask these Societies to initiate measures that will assist the community in improving medical care. I think that whenever our City, through its Hospital or Health Departments, does a good piece of work we should comment upon it. We are always more than willing to comment on their failures, which is right; but we should also recognize their accomplishments. I might add in this respect that a letter was sent to Dr. Harry Mustard, the new Commissioner of Health, and to the Mayor of the City on his appointment of Dr. Mustard. All of you may not be acquainted with Dr. Mustard, but I can tell you that in the field of public health he is without equal. The citizens of New York should take real pride in his appointment. In a community of this size there are many ways for us to participate in and supplement the plans which concern the physical and mental welfare of our neighbors. Lay groups of women in the city occasionally ask us for physicians who can discuss with them some current medical problem. At the present time, of course, the most pressing question is that of food and adjustment of the diet to the request for curtailment of certain specific foods. Where we can co-operate with requests of this kind we shall try to do so. Naturally, we feel that many such requests should be referred to the Information Service of the Academy of Medicine, and whatever we do will be in co-operation with its already existing agency.

A third way in which we can act is in informing young women regarding the opportunities for women in the profession of medicine. We have written to the Deans of women's colleges in the vicinity of the city, advising them that among our members we have physicians who would be able to discuss with their students the type of opportunity open to women in medicine. I think it is important for young women who contemplate the study of medicine to appreciate what that means and to know what they can expect from a professional life. Since the medical schools are obviously limited as to the number of students they can properly handle, it is important that women planning to study medicine should be fully aware of their responsibilities. Under existing conditions it is unfair for an individual to have the advantages of a medical education and not fulfill its obligations.

Finally, as a group of individuals with a great deal in common, this Association should provide us with an opportunity of knowing one another better. This is an important part of our Association because it promotes friendship and understanding among individuals,, and this inevitably contributes to good-will. If good-will is to exist among nations, it must have its foundation amongst people, and I honestly believe that it can be promoted in simple ways, such as this meeting we are having this evening.

In brief, then, it seems to me that our purposes are those of any and every association of physicians: to contribute as a group to measures aimed at improving the medical care of the people in the community; to support the larger organizations to which we belong as individuals and to take an active part in their programs; to help diffuse information to women physicians of other nations; and, finally and most important of all,

to provide a background for developing our mutual understanding and friendliness—which I hope would extend beyond the immediate boundaries of this Association. The incredible display of new inventions in the past seventy years has focussed the attention of people on the material side of civilization. Each group of individuals that redirects its attention towards human problems helps in the development of a more generous attitude of mind, and as an asssociation of physicians we have indeed an unusual opportunity to do this.

RESEARCH FELLOWSHIPS

Announcement of the availability of four research fellowships to be awarded for one year in the fields of medicine, dentistry, and pharmacy at the stipend of $1,800 per year has been announced by the University of Illinois graduate school.

Appointments cover a calendar year with a one month vacation. Fellows are eligible for reappointment in competition with the new applicants.

Candidates for fellowships must have completed a training of not less than eight years beyond high school graduation. The training may have been acquired in any one of the following ways, or the equivalent thereof:

1. Work leading to the B.S. and M.D. degrees (in some instances the candidates would have the M.S. degree, or an additional year or two of hospital training beyond the interne year).
2. Work leading to the B.S., M.S., and D.D.S. degrees.
3. Work leading to the B.S. or B.A. degree in a four-year collegiate course and to the D.D.S. degree.
4. Work leading to the B.S., D.D.S., or M.D. degrees.
5. Work leading to the B.S. or B.A. degree followed by a degree in pharmacy (4 year course).
6. Three years of collegiate work followed by a degree in pharmacy (4 year course) and M.S. degree in pharmacy.

Candidates should indicate the field of research in which they are interested and submit transcripts of their scholastic credits, together with the names of three former science teachers as references. Appointments will be announced January 1, 1948, or shortly thereafter. The fellowship year begins on July 1, 1948, and in some cases on September 1, 1948.

Formal application blanks may be secured from the Secretary of the Committee on Graduate Work in Medicine, Dentistry, and Pharmacy, 1853 W. Polk Street, Chicago 12, Illinois.

More Liberal Requirements For Fellowships

The U. S. Public Health Service announces new and more liberal eligibility requirements for research fellowships in order to increase the number of trained scientists. Formerly the fellowship program was limited to students with master's degrees but now it will be open to those with bachelor's degrees, and they will receive in addition to tuition fees stipends of $1,200 if they have no dependents and $1,600 if they have dependents. The stipends for fellows with master's degrees will be tuition fees plus $1,600 without or $2,000 with dependents, and those holding doctor's degrees will receive $3,000 and $3,600 respectively. Fellowships are awarded for one year but may be renewed. Application forms are available at the National Institute of Health, Bethesda, Md.

Current Publications of Women in Medicine

Ferrer, M. Irene, and Sokoloff, L.: The antidiuretic effect of morphine and demerol in congestive heart failure, (From Department of Therapeutics, New York University College of Medicine, and Third (New York University) Medical Division, Bellevue Hospital.)
Am. J. M. Sc. *214:* 372-384, Oct. 1947.

"The influence of morphine on mercurial diuresis was studied in nine patients with congestive heart failure.

Authors suggest that the antidiuretic effect of morphine and demerol, while probably not operative in all patients, cardiacs or otherwise, is of sufficient importance in some cases of cardiac decompensation to account for certain poor results with mercurial diuretics.

Silberberg, M. and **Silberberg, Ruth:** Hair growth in the skin of guinea pigs painted with 20-methylcholanthrene. Arch. Path. *44:* 297-306, Sept. 1947.
(From Snodgras Laboratory of Pathology, City Hospital, St. Louis.)

"Prolonged application of 20-methylcholanthrene produced in the skin of guinea pigs mild hyperplasia of the epidermis with increased mitotic proliferation of the basal cells. Although there were scattered hairless areas in the painted skin, growth of hair was rapid. This report deals with the histologic changes observed in hairs of the painted skin of these animals."

Spiegel-Adolf, Mona, and Sano, M. E.: Ultraspectrophotometric studies of extracts of normal and of tumor tissue of human origin. Arch. Path. *44:* 307-313, Sept. 1947.
(From the Department of Colloid Chemistry and the Agnes Barr Chase Cancer Research Foundation, Temple University School of Medicine and Hospital, Philadelphia.)

"Ultraspectrophotometric studies of extracts of normal and of tumor tissue of human origin were made with the following results. Tissues from carcinoma and lymphosarcoma gave practically uniformly selective absorptions peaks at 2,600 angstrom units. Extracts from inflammatory lymph nodes had their maximum of selective absorption at 2,500 units, while normal liver and endometrium had their height of absorption at 2,650 units."

Horstmann, Dorothy M., Melnick, J. L., Ward, R., and Jose Sá Fleitas, M. The susceptibility of infant Rhesus monkeys to poliomyelitis virus administered by mouth. A study of the distribution of virus in the tissues of orally infected animals. J. Exper. Med. *86:* 309-323, Oct. 1947.
(From Section of Preventive Medicine of Yale University School of Medicine.)

"Although rhesus monkeys have been generally regarded as refractory to infection with poliomyelitis virus administered by the oral route, two of seven infant rhesus monkeys developed paralytic poliomyelitis when fed murine-adapted strains of virus.

Studies on the distribution of the virus in the tissues yielded positive results in only one animal, virus being isolated from the spinal cord, buccal mucosa, duodenal wall, colon contents, superficial lymph nodes, spleen, heart, and adrenals.

Jackson, R. L., Kelly, Helen G., Rohret, Cecilia Healy, and **Duane, Julia M.:** Rheumatic fever recurrences in children without sulfonamide prophylaxis: an evaluation of environmental factors. J. Pediat. *31:* 390-402, Oct. 1947.
(From Department of Pediatrics and State Services for Crippled Children, State University of Iowa.)

In this study 266 patients were under observation a total of 893.5 person-years, between the ages of 4 to 21 years. The recurrence rate in this study group which received special attention to improve their diets and level of environmental care is significantly different from that reported by Wilson for a random sample and from a comparable Iowa group that did not receive improved environmental care the first year after onset. The age from 4 to 13 years is the period in which nutritional requirements of the child are high and when his habits of living can be controlled with less difficulty than from approximately age 14 years and older. The most significant association between the environmental factors and the distribution of the recurrences was found for the dietary factor. Authors recommend that every precaution be taken to be certain the disease is inactive before liberating the child.

Norval, Mildred A.: Some factors which influence the duration of breast feeding. J. Pediat. *31:* 415-419, Oct. 1947.
(From Mayo Foundation, Rochester, Minn.)

The duration of breast feeding in a group of 462 women was investigated in relation to certain factors in both the mothers and their infants. After women reach the age of 30 years, there is a decrease in the adequacy of the supply of breast milk, particularly among those delivered of their first living child. The age of the mother did not affect the duration of breast feeding, once it had become established. Parity did not influence the supply of breast milk. Women living in the country breast fed their infants 0.8 months longer than city women. The relationship between time and degree of engorgement and breast feeding was also noted. The birth weight of the infant did not influence the adequacy of the milk supply or duration of breast feeding.

Swiller, Helen E., Swiller, I. A., and Traub, F. B.: Salmonella carrier treated successfully with streptomycin. J. Pediat. *31:* 474-475, Oct. 1947.
(From Jewish Hospital of Brooklyn.)

An infant in the carrier state of Salmonella infection was successfully treated with streptomycin administered in large doses orally over a prolonged period of time.

Sherfey, Mary J.: Psychiatry belongs at the bedside. Am. J. Nursing, *47:* 682-685, Oct. 1947.
(From Payne Whitney Psychiatric Clinic, New York Hospital.)

"The 'good nurse' understands how emotions can influence the behavior of both her patient and herself."

Morgans, Margaret E. (M.R.C.P.): Gaucher's disease without splenomegaly. Lancet, *2:* 576-578, Oct. 18, 1947.
(From Medical Unit, University College Hospital Medical School, London.)

Description of a family affected by Gaucher's disease in whom none of the affected individuals showed splenomegaly. Diagnosis was made by detection of Gaucher cells in the bone-marrow and by the presence of typical radiological lesions in the bones. The family history suggests that the disease was hereditary as well as familial and congenital. All of the individuals had led or were leading active lives and diagnosis in one case was made at 67 years of age.

Morrison, Brenda: A study of burns and scalds in children. Arch. Dis. Childhood, *22:* 129-151, Sept. 1947.
(From Children's Department, Royal Victoria Infirmary, Newcastle-on-Tyne.)

Thirty-one cases of burns and scalds in children were studied and an attempt was made to define the symptomatology of the different phases of the constitutional disturbance, and to correlate the physical signs with the simple hematological data. 18 graphs, 6 tables.

McIlrath, Muriel B. (M.B., F.R.C.S., M.R.C.O.G.): Primary carcinoma of the vagina: A brief review of the literature and reports of four cases. M. J. Australia, *2:* 231-234, Aug. 23, 1947.
(From Royal Prince Albert Hospital, Sydney.)

From 1937 to 1947, only four cases were encountered in the Gynaecological Department of King George V. Memorial and the Royal Prince Alfred Hospitals. The present day knowledge of pathology and treatment is reviewed.

Loveless, Mary H. and **Brown, Halla:** A comparison between the clinical effects of pyribenzamine and those of benadryl. New England J. Med. *237:* 501-504, Oct. 2, 1947.
(From Cornell University Medical College and New York Hospital.)

Among 150 patients given pyribenzamine and 53 given benadryl by mouth, partial or complete control of symptoms was noted in over 80 per cent of those with acute urticaria or allergic rhinitis of seasonal (pollen) origin. In 33 cases of cross trials, 23 patients obtained equal relief with the two; 5 preferred benadryl; and 5 preferred pyribenzamine. Administration of the drugs to allergic persons during "constitutional" reactions in 20 cases produced encouraging results for urticaria, hay fever, and mild bronchial spasm, but severer asthma seemed to resist their influence.

Goerner, Jessamine R., Massell, B. F., and Jones, T. D.: Use of penicillin in the treatment of carriers of beta-hemolytic streptococci among patients with rheumatic fever. New England J. Med. *237:* 576-580, Oct. 16, 1947.

(From Departments of Medicine and Preventive Medicine, Yale University School of Medicine.)

Eighteen chronic carriers of beta-hemolytic streptococci and 2 cases of acute streptococcal tonsillitis were treated with a total of 1,200,000 units of penicillin each, given intramuscularly during ten days. The infecting organisms were eliminated in 17 cases permanently from the throat cultures. One Group A streptococcus and two that did not belong to Group A, C, or H failed to disappear.

Fromm-Reichmann, Frieda: Problems of therapeutic management in a psychoanalytic hospital. Psychoanal. Quart. *16:* 325-356, 1947.

(From Chestnut Lodge Sanitarium, Rockville, Maryland.)

The problems of privileges, management of patients, and reactions of both patient and psychoanalyst are discussed.

Wheeler, W. E. and **Scholl, Mary Louise L.:** Determination of anti-Rh antibody in infants with erythroblastosis fetalis. Am. J. Dis. Child. *74:* 274-282, Sept. 1947.

(From Department of Pediatrics, Ohio State University College of Medicine, and Children's Hospital.)

A method for the liberation of anti-Rh antibody by heat from its combination with the red cells of a baby with erythroblastosis is described. The method will demonstrate both the complete and incomplete type of antibody. Case report illustrating value of positive diagnosis. In 19 of 20 cases of erythroblastosis seen after paper was submitted for publication, antibody was liberated according to described method.

Kohn, J. L., Rudel, G., Weichsel, M., Buxbaum, L., Fischer, A. E., **Guinther, Dorothea H.,** and **Lodyjensky, Catherine:** Hyperimmune serums in treatment of whooping cough. Clinical results, with notes on bacteriologic studies and cutaneous tests. Am. J. Dis. Child. *74:* 321-333, Sept. 1947.

(From Willard Parker Hospital, Department of Hospitals, New York.)

Discussion of a group of 201 patients who had received treatment outlined in a previous report plus either human hyperimmune whooping cough serum or a refined rabbit serum. Results suggest that human hyperimmune serum or globulin should be used in treatment of all infants who are seriously ill with whooping cough.

Pyle, Marjorie M.: Relative numbers of resistant tubercle bacilli in sputa of patients before and during treatment with streptomycin. Proc. Staff Meet. Mayo Clin. *22:* 465-473, Oct. 15, 1947.

(From Division of Experimental Medicine, Mayo Foundation.)

A method was devised for determining sensitivity to streptomycin at the time of isolation of a culture of Mycobacterium tuberculosis by adding streptomycin in various concentrations to a solid medium. Clinical material was obtained from 8 patients with pulmonary tuberculosis. During chemotherapy there was a gradual increase in the number of resistant organisms and the degree of their resistance. Evidence indicates that genetic variation and selection may be of prime importance.

McLeod, Mary Margaret: Therapy of tetanus. North Carolina M. J. *8:* 634-637, Oct. 1947.

General discussion of therapy including control of spasm, administration of antitoxin, care of wound, supportive treatment, prevention and treatment of complications, and prophylaxis against future attacks.

Felshin, Gertrude, and **Topper, Anne:** Protracted illness in children, a probable cause of hormonal deficiency. The effect of thyroid therapy. J. Mt. Sinai Hosp. *14:* 770-777, Sept.-Oct. 1947.

Four groups of ailing children in whom growth was stunted were studied, at the Mount Sinai Hospital. The effect of thyroid therapy in promoting growth in these children was noted in their increased height and acceleration of bone growth during the period of treatment and led to the conclusion that such therapy is an effective, safe, and simple method of stimulating growth. Each group is illustrated by one case report.

Rambar, A. C., **Howell, Katherine,** and Denenholz, E. J.: Pertussis-parapertussis vaccine. J. Pediat. *31:* 556-559, Nov. 1947.

(From Sarah Morris Hospital for Children and Department of Bacteriology, Michael Reese Hospital, Chicago.)

Studies on infants of a vaccine containing equal parts of concentrated solutions of H. pertussis and B. parapertussis lead authors to believe that immunity can be established against parapertussis. They suggest that vaccines given to infants to prevent whooping cough should also contain B. parapertussis vaccine. It is not unlikely that many so-called failures after pertussis vaccine will be prevented by the use of a combined vaccine.

Ralli, Elaine P.: Management of the complications of diabetes. Connecticut State M. J. *11:* 892-897, Nov. 1947.

(From Department of Medicine, New York University College of Medicine.)

General discussion of the complications on the basis of (1) physiological disturbances which by greatly increasing severity of the diabetes result in dehydration and overproduction of ketone bodies, (2) degenerative complications involving the arteries and, as a rule, not affecting the diabetes, and (3) complications due to a disturbance in the interrelationship of the internal secretions. Management is discussed on this basis.

Browne, Florence A.: Mineral oil—a health hazard. Connecticut State M. J. *11:* 903-905, Nov. 1947.

(From Bureau of Maternal and Child Hygiene, State Department of Health, Hartford.)

Physicians should not only **not** recommend use of mineral oil but should warn patients against it. Especially in pregnancy should mineral oil be banned. To the pregnant woman and the developing fetus, more not less, vitamins and minerals should be available.

Ferguson, Margaret S.: A survey of forty-seven cases of anterior poliomyelitis. Glasgow M. J. *28:* 323-327, Oct. 1947.

(From Knightswood Infectious Disease Hospital, Glasgow.)

A study of admissions to hospital about six months before it became evident that anterior poliomyelitis was rapidly increasing in incidence revealed a slightly more frequent occurrence of neuroviral manifestations. A case report of particular interest in this respect is described. The forty-seven cases are discussed with respect to age distribution, frequency of involvement of muscle groups, cerebrospinal fluid examinations, and treatment. Differential diagnosis is also provided by the number of cases erroneously diagnosed as anterior poliomyelitis. A table illustrating this is given.

Loosli, C. G., **Smith, Margaret H. D.,** Gauld, R. L., Robertson, O. H., and Puck, T. T.: Control of cross-infections in infants' wards by the use of triethelyene glycol vapor. Am. J. Pub. Health. *37:* 1385-1398, Nov. 1947.

(From Department of Medicine, University of Chicago; Department of Pediatrics, and School of Hygiene and Public Health, Johns Hopkins University, Baltimore.)

Results of a study conducted on the control of cross-infections by use of triethylene glycol vapor on the infants' wards of the Harriet Lane Home, Johns Hopkins Hospital, from October 15, 1945, to May 1, 1946.

Schmideberg, Melitta: Learning to talk. Psychoanal. Rev. *34:* 296-335, July 1947.

Discussion of origin of adult speech and relations of certain conditions in later life to speech.

Newman, Grace T.: The vaginal smear as an aid in the diagnosis and treatment of gynecological conditions. M. Woman's J. *54:* 20-26, Oct. 1947.

This paper is an attempt to interest more physicians in using the vaginal smear as a diagnostic aid in treating patients who present gynecological and endocrine problems.

Roth, Catherine H.: Testosterone therapy in malignant diseases of female breast and pelvis. M. Woman's J. *54:* 17-19, Oct. 1947.

Caution is advised in the use of androgenic preparations in the treatment of cancer of the breast, ovary fallopian tube, body of the uterus, and cervix since these have received little clinical trial and not all of it has been encouraging.

Rogers, Gertrude A.: Treatment in child psychiatry. M. Clin. North America, 1216-1226, Sept. 1947.

(From the Department of Psychiatry, Harvard Medical School, and Boston Psychopathic Hospital.)

The problems of classification of childhood disorders and treatment from the standpoint of direct and indirect therapy and group psychotherapy are discussed. A case illustrating the problems and procedures is described.

Odell, L. D., **Aragon, Gloria T.,** and Pottenger, R. E.: Relationship between erythrocyte sedimentation rate, sludged blood, and plasma proteins during pregnancy. Am. J. Obst. & Gynec. *54:* 596-610, Oct. 1947.

(From Department of Obstetrics and Gynecology, University of Chicago School of Medicine, and Chicago Lying-in Hospital.)

A total of 52 pregnant and nonpregnant subjects were studied. These included 21 whose pregnancy was normal and 23 whose pregnancy was complicated.

Summary: "Sludged" blood, as characterized by intravascular agglutinations and reduced rate of flow, is found in normal and pathologic pregnancy and in some nonpregnant women. This phenomena is apparently related to an increased erythrocyte sedimentation rate, which, in turn, correlates with plasma fibrinogen and albumin values. It is possible to make estimates of erythrocyte sedimentation rate from the microscopic conjunctival observations.

During shock "sludge" is apparently related to subsequent hemodiliution or to the accompanying operative trauma, rather than to an acute loss of blood. During thrombophlebitis and infections the size of intravascular masses is particularly increased. During preconvulsive toxemias "sludge" is increased, and during eclampsia anoxia could explain the rapid loss of plasma to the tissues. 6 tables.

Schmitz, H. E., Bremner, J. X., **Towne, Janet E.,** and Baba, G. R.: The management of prolonged labor. A four-year review from the Lewis Memorial Maternity Hospital. Am. J. Obst. & Gynec. *54:* 596-610, Oct. 1947.

Prolonged labor is usually the result of an ineffectual type of uterine contraction and shows a definite increase of fetal mortality. The morbidity rate is increased in patients in labor more than twenty-four hours. The elderly primipara group shows a higher percentage of prolonged labor and the elderly primipara group in prolonged labor shows a marked increase in the fetal mortality over the younger age group.

Wammock, Virgene S.: The practical application of penicillin in treatment of syphilis. J. Am. M. Women's A. *2:* 425-432, Oct. 1947.

(From Institute for Study of Venereal Disease. University of Pennsylvania and Woman's Medical College of Pennsylvania.)

Penicillin is effective treatment for early syphilis, benign late syphilis, asymptomatic and symptomatic neurosyphilis, and infantile congenital syphilis. This form of therapy, properly given, surpasses all others in the treatment of syphilis in pregnancy. Dosage to be employed in the various types of syphilis are detailed in text.

Spears, Mary M., and **Pfeiffer, Mildred C. J.:** The relationship of anorectal lesions to disease in general. J. Am. M. Women's A. *2:* 433-436, Oct. 1947.

(From Departments of Gastro-enterology and Proctology and Medicine, Woman's Medical College of Pennsylvania.)

Discussion of the broader aspects of anal and rectosigmoidal disease with the purpose of indicating the inter-relationships with other organ systems.

Wertenberger, Grace E., and **Hafkesbring, H. Roberta:** Sulfonamides and the electrocardiogram. J. Am. M. Women's A. *2:* 440, Oct. 1947.

(From Department of Physiology, Woman's Medical College of Pennsylvania.)

Cardiovascular function should be frequently checked when patients are being given sulfonamides. Electrocardiographic studies might well parallel the course of treatment.

Stilwell, E. Frances: Multipolar mitoses in tissue cultures. J. Am. M. Women's A. *2:* 441, Oct. 1947.

(From Department of Anatomy, Woman's Medical College of Pennsylvania.)

Using blood plasma, obtained by heart puncture from fowls, chick embryonic juice from minced chick embryos was cultured by the coverglass method of Maximow. Multipolar mitoses have been produced from eighteen or more series of cultures. As yet no specific factor can be named as being responsible for their appearance.

Baumann, Frieda, Crump, Jean, Arthurs, Ann Catherine, Seager, L. D., and **Miller, Ruth E.:** Penicillin therapy in bacterial asthma. J. Am. M. Women's A. *2:* 442-444, Oct. 1947.

(From Woman's Medical College of Pennsylvania.)

Brief discussion of the use of penicillin in intrinsic or bacterial asthma and description of the type of case selected for oral penicillin therapy. Outline of a plan of treatment in detail.

van Loon, Emily L., and **Coonel, Pauline:** Bronchoscopy in the child with chronic cough. J. Am. M. Women's A. *2:* 444-445, Oct. 1947.

(From Woman's Medical College of Pennsylvania.)

Three cases in which bronchoscopy was used are described. "Bronchoscopy should be considered in any chronic cough of childhood which does not yield to other treatment. In experienced hands, it is a safe, brief, and fairly painless procedure which aids in diagnosis and treatment."

Vastine, Mary Frances, and Vastine, J. H.: Roentgen therapy to the pituitary gland in certain benign conditions of the breast. J. Am. M. Women's A. *2:* 446-448, Oct. 1947.

(From Department of Radiology, Woman's Medical College of Pennsylvania.)

Mastodynia and cystic disease have been treated by administration of small infrequent doses of roentgen therapy to the pituitary gland (70r, every two weeks for two to six doses). Relief of pain has resulted promptly in practically every case so treated. The recurrence of cysts following excision or aspiration in some cases of cystic disease seems to have been averted by this mode of therapy. It is postulated that roentgen therapy has its effect by depressing the basophilic cells of the pituitary gland.

Wight, Susan C.: Lead poisoning in childhood. J. Am. M. Women's A. *2:* 448-449, Oct. 1947.

(From Department of Pediatrics, Woman's Medical College of Pennsylvania.)

Report of a case of chronic lead poisoning with encephalitis and colitis in a three year old child. Significant findings included: hypochromic anemia with coarse basophilic stippling of red blood cells and increased density at the ends of the shafts of the long bones.

Pettit, Mary De Witt, and **Slater, Florence C.:** Rectovaginal fistula due to tuberculosis. J. Am. M. Women's A. *2:* 449-450, Oct. 1947.

(From Department of Gynaecology, Woman's Medical College of Pennsylvania.)

Case report.

Waugh, Elizabeth S., and **Grace, Helen K.:** Uterus couvelaire. J. Am. M. Women's A. *2:* 451-452, Oct. 1947.

Two case reports.

Maher, Irene E.: The rational use of digitalis. J. Am. M. Women's A. *2:* 453-456, Oct. 1947.

(From the Woman's Medical College of Pennsylvania.)

Cardiac glycosides are a valuable adjunct to digitalis therapy but should not be used without knowledge of their individual characteristics.

Give Them This Day

Help 230,000,000 children of the world to survive hunger and privation . . . contribute to this world-wide action for the suffering children of today—tomorrow's citizens . . . support the United States government foreign aid policy . . . build the Children's Century, the peace that can march forward on the feet of little children . . . GIVE THEM THIS DAY the American way, through American Overseas Aid—United Nations Appeal for Children, 39 Broadway, New York 6, N. Y.

BOOK REVIEWS

(EDITOR'S NOTE:—*These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of this* JOURNAL.)

SURGERY OF THE AMBULATORY PATIENT. By L. Kraeer Ferguson, M.D., F.A.C.S., Professor of Surgery, Woman's Medical College of Pennsylvania, Chief of Surgery, Graduate School of Medicine, University of Pennsylvania. With a section on Fractures by Louis Kaplan, M.D., F.A.C.S., Associate in Surgery, University of Pennsylvania, Chief of Surgical Service II, Mt. Sinai Hospital, Philadelphia. 2d edition. 932 pp., 645 illustrations. $10.00. J. B. Lippincott Company, Philadelphia, 1947.

As the author points out in the preface, this treatise on surgery of the ambulatory patient was written as an aid to young physicians and general practitioners who treat surgical conditions not necessitating hospital care. He considers this to be a much neglected branch of surgery, and in a comprehensive volume covers the entire subject thoroughly. The book is divided into three parts. The first is concerned with general discussion of this field of surgery: its advantages and disadvantages, specific surgical lesions and infections, their cause, course, and treatment. The chapter on anesthesia is modern and very informative.

The second portion is devoted to regional surgery and, after a brief description of the anatomy of the part, all injuries, tumors, and infections, and their treatment are described. This is an excellent method of presentation with many useful illustrations.

In the third section, fractures and dislocations and their treatment are adequately discussed. The author and his collaborators have gathered and assembled valuable material, including in this second edition therapy with penicillin and sulfa drugs. New material has been added on tendon suture, varicose veins, and lesions of the back. Common mistakes have been discussed. The arrangement of the book, as well as its wealth of material, including 645 graphic illustrations, make it a very encyclopedia of information. It is an especially valuable contribution, since there is no other single volume on the subject and it is to be recommended to every physician doing this type of work.

—Frances H. Bogatko, M.D.

THE PREMATURE BABY. By V. Mary Crosse, M.D. (London), M.M.S.A., D.R.C.O.G., England. Chief Obstetric officer in charge, City of Birmingham Maternity Homes and Premature Baby Unit; Deputy Senior Assistant Medical Officer of Health (for Maternity and Child Welfare), City of Birmingham; Examiner for Central Midwives Board, etc. 156 pp., 14 illustrations. $3.00. The Blakiston Co., Philadelphia. 1947.

This is an excellent little book that should prove invaluable to obstetricians, pediatricians and nurses. The handling of premature babies is explained with such attention to detail that it is a real manual of procedure from the moment of birth until the infant is turned over to the mother. This volume fills a great need in all maternity units, and if followed conscientiously, should decrease markedly the death rate of premature infants. Even allowing for recent increased knowledge of chemotherapy and antibiotics in the treatment of infections of the premature baby, this book should become a text-book in the teaching of doctors and nurses responsible for the care of premature babies, since the technique may apply either to one single infant or large nursery units.

—Carlota Mendez, M.D.

INTERNAL MEDICINE IN GENERAL PRACTICE. By Robert Pratt McCombs, B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. 2d Edition., 741 pp., with 122 illustrations. $8.00. W. B. Saunders Company, Philadelphia and London, 1947.

The Director of Postgraduate Teaching at Tufts College Medical School has given in this book a concise and practical review of internal medicine. It is of especial value, not only to general practitioners, but to those who wish a readable orderly summary of diagnosis and treatment in present-day internal medicine.

Such a review is appreciated at this time when the steady accumulation of current periodicals discourages most of us about ever getting "read up". Evaluation of new reports throughout the field of internal medicine requires more time than we can find. Use of the Index and reference to large medical texts are necessary for special topics of individual interest. It is easy thus to see the trees but lose the forest. Dr. McCombs offers a bird's eye view of the whole forest, yet with enough attention to individual topics to make us feel that we have seen the trees too. This satisfaction is achieved through including discussions of the underlying physiological defects in disease, such as the causes of edema, the changes that occur in renal failure, etc. There are also practical summaries of the significance of specific clinical and laboratory findings.

The chapter headings give some idea of the arrangement: Fundamentals of Diagnosis; Psychiatric Disorders; Disorders of the Heart; Hypertension and Diseases of the Kidney and Urinary Tract; Disorders of the Gastro-intestinal Tract; Nutritional Deficiencies; The Anemias; Blood Dyscrasias and Allied Diseases; Infectious Diseases; The Use of the Sulfonamides, Penicillin, and Streptomycin; Chronic Lung Diseases; Rheumatic Diseases; Endocrine Disorders; Allergic Diseases; Diseases of the Nervous System; Vascular Disturbances of the Extremities.

The book can easily be read from cover to cover in several sittings. It has a number of illustrations, schematic drawings, x-ray pictures, colored plates, and tables.

It is to be hoped that new material required in later editions can be introduced by deletion and revision so that the size of the book will not be increased. Its peculiar value lies in its studied brevity.

—Elisabeth C. Adams, M.D.

NURSING. By Lulu K. Wolf, R.N., B.S., M.P.H., Professor of Nursing, Vanderbilt University School of Nursing. 505 pp., with 203 illustrations. $3.50. D. Appleton-Century Company, New York, London, 1947.

This is a fine reference work for both student and graduate nurses. It stresses the role of "health teacher" for the nurse. In all three parts into which it is divided it makes very clear the point that the nurse has an obligation not only to nurse the sick but to keep well people well. It has a completely modern slant on the nurse, her duty to the patient, the family, and the community, and her place in the world health picture.

Part I, "Orientation to Nursing", is devoted to the history of the profession. It carries the story from the beginnings of modern nursing, as first developed by St. Vincent de Paul, by the deaconesses at Kaiserwerth, and by the true founder of modern nursing, Florence Nightingale, on through our Civil War and the recognition of nursing as a profession in this country. It takes us through most of the "firsts", such as the formation of the American Nurses' Association, the National Organization for Public Health Nursing, and so on. It lists various legislative measures for control of nursing practices and brings us up to the present day with a discussion of the nation's health problems and the proper preparation for present day nursing. In this section much space is devoted to the individual in the nursing profession. There is discussion of various problems which may present themselves to the young nurse, and this is especially useful in the orientation program for the student nurse. Many situations which she may meet and with which she may have difficulty are here clarified.

Part II, "Orientation of the Nurse to the Hospital", includes a discussion of hospital growth and development and covers the topics usually considered under hospital housekeeping.

Part III, "Orientation to Patient Care", describes the nursing care of the patient during both simple and more complex treatments.

"Nursing" can be highly recommended as a fine, modern reference text for nurses.

—Rosemary Holthusen, R.N.

COMMUNICABLE DISEASES. By Franklin H. Top, M.D., M.P.H., F.A.C.P., Medical Director, Herman Kiefer Hospital; Clinical Professor of Preventive Medicine and Public Health, Wayne University College of Medicine; and Collaborators. 992 pp., illustrated. 2nd Edition. C. V. Mosby Company, St. Louis, 1947. $8.50.

This, the second edition of a detailed reference book on communicable diseases, discusses in precise form the different communicable diseases, their clinical picture, symptoms, pathology, immunology, and the newest therapy. It includes conditions relatively rare, such as Coccidioides mycosis, as well as more common ones, such as scabies and ringworm of the scalp, which has recently developed into a real public health problem.

Each chapter is written by a group of experts and includes a good bibliography and list of suggested readings. The illustrations are excellent.

This is a valuable reference book for students, nurses, and practicing physicians.

—Anne F. Casper, M.D.

TEXTBOOK OF THE NERVOUS SYSTEM: A Foundation for Clinical Neurology. By H. Chandler Elliott, M.D., Ph.D., Assistant Professor of Anatomy, Medical College of the State of South Carolina. Introduction by Wilder Penfield, M.D. 384 pp., 158 illustrations, 62 subjects in color, with atlas. $8.00. J. B. Lippincott Company, Philadelphia, 1947.

This latest anatomical text, from the Department of Anatomy of the State of South Carolina, deals with the nervous system, one of the most difficult parts of anatomy for students and clinicians to visualize. The subject is ably presented, not as an array of dull, easily forgotten tracts and nuclei, the names of which are soon out of mind and never really digested; but as a vital framework, the growth, the function, and the many details of which still need investigation and clarification. The text, which includes mention of the latest research, is calculated, not only to stimulate the interest of medical students, but to inculcate in some of them a genuine scientific curiosity in neuro-anatomical research. The book is, as the title says, a foundation for the study of clinical neurology. The Introduction, written by Dr. Wilder Penfield, emphasizes the rich reward that the study of neuro-anatomy brings to the student of neurosurgery.

Part I of the text presents an outline of the nervous system. Part II is an elaboration of this outline. There are many excellent plates and explanatory diagrams, which are well thought out and carefully and clearly presented. Two appendices cover the vocabulary of neurology, giving the origin of terms most frequently used. The bibliography is completely up to date, covering the literature of the past ten years.

This text should be useful, not only in teaching in medical schools, but as a reference, because of the inclusion of the current advances and contributions made to the study of neurology in the years immediately preceding and during the Second World War.

—Kate Constable, M.D.

BONE AND BONES: FUNDAMENTALS OF BONE BIOLOGY. By Joseph P. Weinmann, M.D., College of Dentistry, University of Illinois; formerly at School of Dentistry, Loyola University, Chicago; and Harry Sicher, M.D., School of Dentistry, Loyola University, Chicago. 464 pp., with 289 illustrations. $10.00. The C. V. Mosby Company, St. Louis, 1947.

This volume is an easily readable exposition of the structure of bone and the function of bone as an organ or collection of organs. The chapter on the structure and engineering feats of bone formation are particularly interesting, as are those on the relationship between the formation of cartilage and that of bone.

The book is recommended to anyone interested in bones, although some additional investigation of the chemistry and biology of bone will be required by most readers.

—Martha E. Howe, M.D.

News of Medical Women

COURAGE AND DEVOTION BEYOND THE CALL OF DUTY

At the Ninth Annual Medical Art Exhibit held in conjunction with the American Medical Association meetings in Atlantic City last June, the Mead Johnson Company sponsored a special contest for contributions depicting "Courage and Devotion beyond the Call of Duty." Entries totalled 1274. One of our members, Dr. Anna Darrow of Fort Lauderdale, Florida, was awarded a second prize and $1,000 for her painting which tells the story of a pioneer woman physician in the Florida Everglades. It is a simple rural scene of fine composition and balance. By choosing a homely subject and using pure, clear color, Dr. Darrow created an American primitive. In the foreground of the picture, to the left, a Model T Ford stands complete with high spoked wheels, brass trimmings, and crank. Stepping from the car is a slim doctor with red hair, and ample ankle length skirt. She is carrying an obstetrical bag. This is Dr. Darrow in 1920. A little to the right a vindictive red hen with wings spread and feathers ruffled squawks a warning to her brood. Chicks scurry to the rear. In the center of the painting, partly concealed by grass, a rattler coils, prepared to strike. On the right is a humble dwelling. A man stands on the porch. The woman in the doorway is the good neighbor, the volunteer nurse. A girl of four or five runs toward the doctor; a boy of two plays by the door step. Two large birds fly low over the cottage. At first glance they resemble storks, but closer study reveals that the Florida ibis has usurped the traditional duties of baby bringer. It is plain that the doctor and the ibis are running neck and neck in the race to usher twins into the world.

When the contest and its title was announced, Dr. Darrow read of it and thought, "All things must be created in the mind or reflect an experience." "Right then," she says, "I was transported back to an experience of my pioneer days. Stepping out of my Ford, in answer to a hurry call, I saw and heard the little red hen scream a warning to her brood of chicks. There was the huge diamondback rattlesnake. The hen by her challenging cry saved her chicks and perhaps saved my life, too. Here was courage and devotion in an animal. It was fitting that a snake should be in the painting. The snake as a symbol of medicine dates back to antiquity. Snakes or serpents signify knowledge and are employed in the caduceus, with the staff of life, topped by the wings of Mercury, the messenger of the gods. So a

snake is the central figure in my painting. Later in the cabin I saw another mother fight for life when she gave birth to twin sons.

"Quickly I decided that a picture of this visit to a pioneer family would be my contribution to the contest. I put it down on canvas: my trusty Ford of 1911 vintage, the hen and her chicks, the snake, the cabin, the father, the children, and the neighbor, the horse and cart in the shed, the crude fence and the palmettos. As a symbol of approaching motherhood I used Florida ibises in place of storks.

"When the picture was completed I looked at it. Each figure is significant; each is a part of my life. While I had been painting it, the older of the twins was caught in a storm while piloting a plane over Lake Okeechobee, crashed, and was killed, only a few miles from where he was born. The old Model T is in the Henry Ford Museum at Sarasota."

The American College of Physicians Announces Its Annual Session at San Francisco, April 19-23, 1948

The American College of Physicians will conduct its 29th Annual Session at San Francisco, April 19-23, 1948. General Headquarters will be at the Civic Auditorium. Dr. William J. Kerr and Dr. Ernest H. Falconer, both of San Francsico, are the Co-Chairmen for local arrangements and the program of Clinics and Panel Discussions. The President of the College, Dr. Hugh J. Morgan, Professor of Medicine at Vanderbilt University School of Medicine, Nashville, Tennessee, is in charge of the program of Morning Lectures and afternoon General Sessions.

Secretaries of medical societies are especially asked to note these dates and, in arranging meeting dates of their societies, to avoid conflicts with the College Meeting, for obvious mutual benefits.

American Congress of Physical Medicine

The American Congress of Physical Medicine held its annual meeting in Minneapolis from September 2 to 6 with a varied program. It was preceded by the meeting of the Board of Physical Medicine for examinations, discussion of the conduct of affairs, and for the annual luncheon on September 3.

A number of women are doing outstanding work in physical medicine, among them Frances A. Hellebrandt, M.D., Professor, Physical Medicine and Acting Director, Baruch Centre Physical Medicine, Medical College of Virginia; Ursula Leden, M.D., Fellow in Physical Medicine, Mayo Clinic, Rochester, Minn.; Marjorie B. Zucker, M.D., Research Assistant, Department of Physiology, Baruch Committee on Physical Medicine, P. & S., Columbia University; Frances Baker, M.D., Assistant Clinical Professor, Orthopedic Surgery, University of California Medical School; Jessie Wright, M.D., Director, D. P. Watson School of Physical Therapy, Pittsburgh, Pa.; Julia F. Herrick, Ph.D., Associate Professor of Physical Medicine, Institute of Experimental Medicine, Mayo Foundation, Rochester, Minn.; Nila K. Covalt, M.D., Veteran's Administration, Washington, D. C.

MEDICAL SCHOOL NEWS

Dr. Eva F. Dodge, Editor

University of Arkansas Medical School
Little Rock, Arkansas

University of Virginia Department of Medicine

Women students at the school represent 4 per cent of the total registration for the Fall session.

Dr. Suzanne Haywood Worrilow, the only woman to graduate in June 1947, is now interning at the Philadelphia General Hospital. During her fourth year she was president of Alpha Omega Alpha.

The majority of the present fourth year women served externships in various departments at the University Hospital during the summer.

Benny Slaughter did interesting work in Dallas, Texas, where she served an externship in medicine under Dr. Tinsley Harrison of Parkland Hospital. Both of the third year women worked in the University Hospital as nurses.

There are four women in the second year class. One of these, Marion Miller, is a registered nurse, a graduate of Western Reserve School of Nursing. During the summer she was employed as a nurse at Cedars of Lebanon Hospital, Los Angeles. Dorothy Reycroft, a graduate of the Sargent School, Boston, worked with the National Foundation for Infantile Paralysis during the polio outbreak in Grand Forks, North Dakota. Gladys Petri-Oms, a native of Puerto Rico, is studying here on a grant from her government, which fact gives that government first call on her services following graduation.

Medical College of Virginia

The Medical College of Virginia opened its 1947-48 session on September 15, with an enrollment of 31 women students, four of them in the freshman class.

The girls of Pi chapter of Alpha Epsilon Iota, which was established at the College in 1923, are looking forward this year to an especially active social and professional program.

University of Texas School of Medicine

The Fall session opened with 34 women students in attendance, 8 of them in the freshman class. They are all hoping that in the very near future they can have a house.

Boston University School of Medicine

The Fall session of the school opened on September 15, with 23 women students, three of them seniors. These seniors will have a full twelve month year, having registered for their fourth year on June 16.

Five of the nine women in the junior class are rated scholastically in the upper third.

Harvard Medical School

The women of the second year class sponsored a tea for the first and third year women at the home of Evelyn Davis on October 4.

FROM DAY TO DAY

(The Chronicle of an Editor)

Saturday, November 1: In the mail, a letter from Dr. Fahimi who has just left on her return voyage to Teheran and who will send us news of our women colleagues in Iran . . . In the afternoon to call on Dr. Dolores Canales and to discuss with her the translation of two articles, written in Spanish, for the **Journal**; to our great satisfaction, Dr. Canales will do this for us herself. This is most fortunate as medical translations often suffer in the process.

Monday, November 3: To the office and to find in the mail a letter from Dr. Montreuil-Straus (Paris): "I read with great interest the **Journal** of the A.M.W.A. and congratulate you on its high standard." Thus the week starts auspiciously!

Wednesday, November 5: A letter from Dr. Gladys Cunningham, Chengtu, China, telling of another woman physician in China who is doing outstanding work in her country. Such an interesting account of Dr. Yang's work that we will publish it in full.

Thursday, November 6: A call from Dr. Emmy Hahn now in this country after several years' stay in England to which she escaped from Germany. Her desire is to do plastic and orthopedic surgery.

Friday, November 7: To a tea at the New York Infirmary in honor of its founder, Elizabeth Blackwell on this, the one hundredth anniversary of the day that she entered Hobart College, Geneva, New York, after having been refused admission by twelve other medical schools. This day is the occasion for radio broadcasts and talks and other publicity from the Library Committee of the A.M.W.A. in their campaign to raise funds for a new library at the Woman's Medical College of Pennsylvania.

Sunday, November 9: In the Sunday Times, an article, "Triumphs of a Pioneer Doctor," about Dr. Alice Hamilton, "first lady of Public Health", who has just received a Lasker Award; first woman on the faculty of that "Stronghold of Masculinity," Harvard University, and the only one of her sex to serve on the Health Committee of the League of Nations . . . Later to the Waldorf-Astoria to the Friendship Dinner, the annual event sponsored by the American Women's Association and participated in by fifty-five women's clubs in the Metropolitan New York area; almost one thousand women present. Dr. Florence Rena Sabin received the Federation award not only as a woman who has made notable contributions through her profession, but also as one who manifests "vision, integrity, and valor." Miss Caroline Diehl, a second-year student at Cornell Medical College, was selected by Dr. Sabin as recipient for the scholarship also awarded at the dinner. A huge birthday cake was presented to the gathering by the hotel and was later sent to the New York Infirmary for the staff and patients.

Monday, November 10: A visit from Dra. Josephine Villafane Martinez of Puerto Rico, who has recently become a member of the A.M.W.A. and who promises to send us an article on the activities of medical women in Puerto Rico.

Tuesday, November 11: A letter from Dr. Gabriele Strecker (who wrote "Medical Women in Germany" for the November **Journal**). She attended the International Women's Congress in Paris, where she met Dr. Montreuil-Straus, Honorary Secretary of the M.W.I.A. Dr. Strecker wrote of the Nuremberg trial of twenty-three German doctors, which ended in August 1947. Among the twenty-three was one woman, Dr. Herta Oberhenser, who "played only a minor role in those gloomy proceedings. She was found guilty and received a sentence of twenty years."

Wednesday, November 12: To Memorial Hospital to the opening of the new building of the Kate Depew Strang Prevention Clinic, and happy to see the well equipped and spacious rooms, recalling the small crowded space first allotted to Dr. L'Esperance when she was starting her Cancer Prevention work. Among the speakers were Dr. Zoe Allison Johnston, past President of the A.M.W.A. . . . Later, to the Beekman Towers, headquarters of the Women's Medical Association of New York City, for a dinner-meeting, having as my guests Dra. Canales, Dr. Ingrid Fehn from Norway, our Mary Putnam Jacoby Fellow, and Dra. Rosa from Peru, now working at Sea View Hospital on Staten Island. Words of welcome from the President, Dr. Elaine Ralli, and so much wisdom therein that we obtained a copy of her remarks (see page 28). The speaker of the evening, Dr. Clarence E. De la Chapelle, gave a very interesting and helpful talk on the management of the patient with coronary disease. Discussion by Dr. Connie Guion and many questions from the floor.

Thursday, November 13: Reading in The American Journal of Public Health (November) that Dr. Florence Sabin has been elected an Honorary Fellow of the A.P.H.A. in recognition of the extraordinary achievements which she has spearheaded in the public health program of Colorado; also, that she has been appointed a member of the Citizens Advisory Council of Social Security of which Edward R. Stettinius, Jr. is Chairman.

Friday, November 14: In the mail, Therapeutic Notes from Parke, Davis & Company with a copy of their advertisement, "See Your Doctor", which is to appear in Life and other magazines. The current message portrays the role of the family doctor as family counselor as well as physician. These messages are rendering a real public service.

Saturday, November 15: From the newsletter of the National Council of Rehabilitation: "Dr. Romaine Mackie, Columbus, Ohio, has been appointed Specialist for Schools for Physically Handicapped, U. S. Office of Education, Federal Security Agency. Prior to her appointment to the Office of Education, Dr. Mackie served as Consultant on Education of the Physically Handicapped in the California State Department of Education. Her twenty years of experience in the special field of education for the handicapped has been obtained in city and state programs in Ohio, New York, and California. Dr. Mackie was civilian coordinator administering the naval (Rehabilitation-Hospital Corps) training program and developed a training program for teachers of the physically handicapped at Hunter College, New York. During her three and a half years at Teachers College, Columbia University, Dr. Mackie helped to organize and teach one of the first courses developed in this country in methods of teaching the crippled." . . . And in the same newsletter, an item which many physicians should find helpful, i.e., the organization of a Benefit Shoe Foundation. Single shoes and odd pairs for adult polios and others with mismated feet are now available from the Benefit Shoe Foundation, Box 98, Bristol, R. I. This is a non-profit organization. Inspiration for the project was Ruth Rubin of St. Louis who had conducted by correspondence a "Shoe Exchange," through which paraplegics and others traded their shoes . . . Received several sets of various medical journals from Drs. Adolph Beyer, Sol Ginsberg, and Erich Buechler, all of New York, to be forwarded

When CONCEPTION IS CONTRA-INDICATED

LACTIKOL JELLY and CREME

- Immobilize sperm INSTANTLY on contact.
- The pH of Lactikol Jelly and Lactikol Creme are both within the normal vaginal range.

Active Ingredients: Lactikol Jelly — Lactic Acid, 1.5%; Glyceryl Monoricinoleate, 1.0%; Sodium Lauryl Sulfate, 0.2%; Oxyquinoline Sulfate 0.05%. Lactikol Creme—Lactic Acid 0.5%; Glyceryl Monoricinoleate, 1.5%; Sodium Lauryl Sulfate, 0.6%.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

WRITE FOR CLINICAL SAMPLES TO DUREX PRODUCTS, INC., Dept. 684 BROADWAY, NEW YORK, N.Y.

through American Relief for Czechoslovakia to Dr. Dwetterova, President of the Czechoslovakia Medical Women's Association, for her to distribute where they will be of most service.

Monday, November 17: With conflicting reports reaching us on the food situation in Europe, it is helpful to read in Health News (New York State) the opinion of Dr. Martha Eliot of the Children's Bureau and President of the American Public Health Association, who has returned from four months' travel in Europe in the interests of the International Emergency Children's Fund. She visited eight countries and found the children stunted and in need of better feeding but she saw actual starvation in Rumania only. Members of the Emergency Children's Fund, to which twenty-six nations are contributors, agree that while clothing is needed, priority must go to food and in the following order: Milk, protein, fats and vitamins, especially cod liver oil.

Tuesday November 18: A letter from Dr. Heise, Copenhagen: "On November 7 the officers of the Danske Kvindelege Laegers Klub met to celebrate the one hundredth anniversary of the entrance of Elizabeth Blackwell to medical school" . . . Also, a letter from Dr. Helen Johnston, enclosing an interesting article, "Woman Flying Doctor Retires: Australia's only woman flying doctor, who has recently retired from practice, attended patients scattered over an area of more than 335,000 square miles. She is Dr. Edna Lyle Thomas of the State of Queensland. Her 'practice,' which extended over half the State, took her during the last six months on seventy flights covering 31,095 miles. In that time she attended 1,031 patients. Dr. Thomas has just completed a diphtheria immunization campaign which took her over practically the whole of northern Queensland. On this work alone she flew 92 hours and covered about 7,200 miles treating hundreds of aboriginal children at mission stations en route. The immunization campaign was instituted at Dr. Thomas' suggestion and she was supported by the Flying Doctor Service of Australia which provides free medical aid for settlers in remote parts of the continent. Dr. Thomas was graduated from the University of Melbourne (Victoria) in 1922 and did postgraduate work in England. On her flying trips her patients were ranch managers and their families, stockmen, boundary riders, drovers, mission staffs, and aborigines."

Wednesday, November 19: To the Biltmore with 600 or more doctors and hospital administrators at a dinner to celebrate the progress of the "Blue Cross Plan" and to hear Bernard Baruch discuss the medical needs of the country.

Thursday, November 20: A telephone call from Dr. Arienti, a friend of Dr. Elisa Bouffier of Milan, Italy, who was one of the observers at the Congress of the M.W.I.A. in Amsterdam this summer, telling us that Dr. Bouffier had received a copy of the **Journal** (J.A.M.W.A.) and liked it so well that she was sending a subscription so she would receive it regularly.

Friday, November 21: A call from the Program Director of the New York Botanical Garden, Mrs. Edward Jerome: "Would our readers want to know of the programs available for club meetings?" The importance of the world of plants to mankind is portrayed, e.g., on December 3, a lecture "Survival Foods of Tropical Jungles" by Richard A. Howard, the report of a botanists' war-time work in teaching airborne troops to meet emergencies of living in the Tropics. A regular program, "Calling All Gardeners," is broadcast every Saturday morning at 8:30 over W.N.Y.C.

Monday, November 24: A letter from Dr. Anni Seppanen: "In the meeting of our Finnish Medical Women's Association, Dr. Eriksson told of her journey to the U. S. and of the help that she had received from the women physicians there in arranging her program." With the letter was an article by Dr. Aino Teittenen, describing her work in cancer in Finland, which we shall publish in our April **Journal**, The Cancer number.

Tuesday, November 25: In LOOK APPLAUDS, a story and picture of Dr. Bertha Van Hoosen: "From a Michigan farm girl she became one of America's leading surgeons and obstetricians. The first woman to hold a surgical clinic at the University of Illinois, she has marked up many other 'firsts' for women doctors. Her crusading work in the use of twilight sleep in childbirth has led to its widespread acceptance in present-day obstetrics. Dr. Van Hoosen's fame has also spread abroad. Recently the International Medical Women's Association voted her an honorary member, the first woman to be so recognized since Marie Curie. She has worked hard all her life but has loved every minute of it, she tells in her recent autobiography, 'Petticoat Surgeon.' Today, at 85, she's still practicing." The **Journal** also applauds Dr. Van Hoosen, founder and first president of the A.M.W.A.

Thursday, November 27: We learn that Dr. Donald A. Covalt has been appointed Associate Professor of Rehabilitation at New York University College of Medicine, and that his wife, Dr. Nila Covalt, has joined the faculty as Assistant Professor of Physical Medicine. Dr. Nina Covalt was the author of the article on Physical Medicine: A Profession for Women Physicians, which appeared in the November **Journal**, and formerly was in charge of Physical Therapy for the Veterans Administration.—**A. C. R.**

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

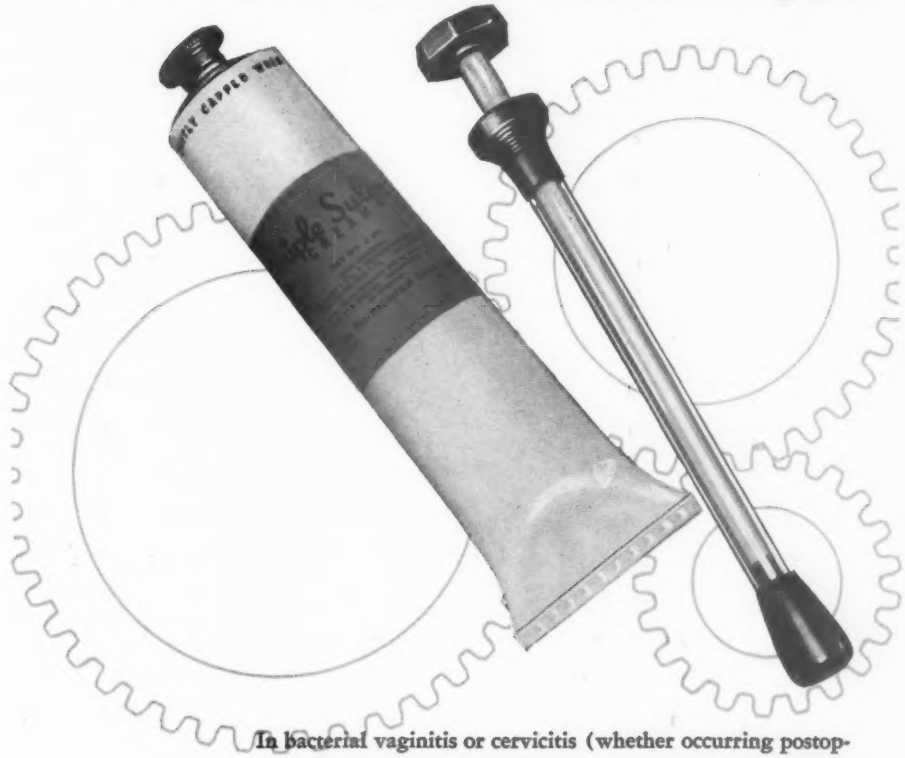
MEAD'S Oleum Percomorphum furnishes 60,000 vitamin A units and 8,500 vitamin D units per gram. Supplied in 10- and 50-cc. bottles. 83-mg. capsules now packed in bottles of 50 and 250. Ethically marketed.

MEAD JOHNSON & COMPANY, Evansville 21, Ind., U. S. A.

Triple Sulfa Cream...

geared for maximum effectiveness

...in the treatment of bacterial vaginitis



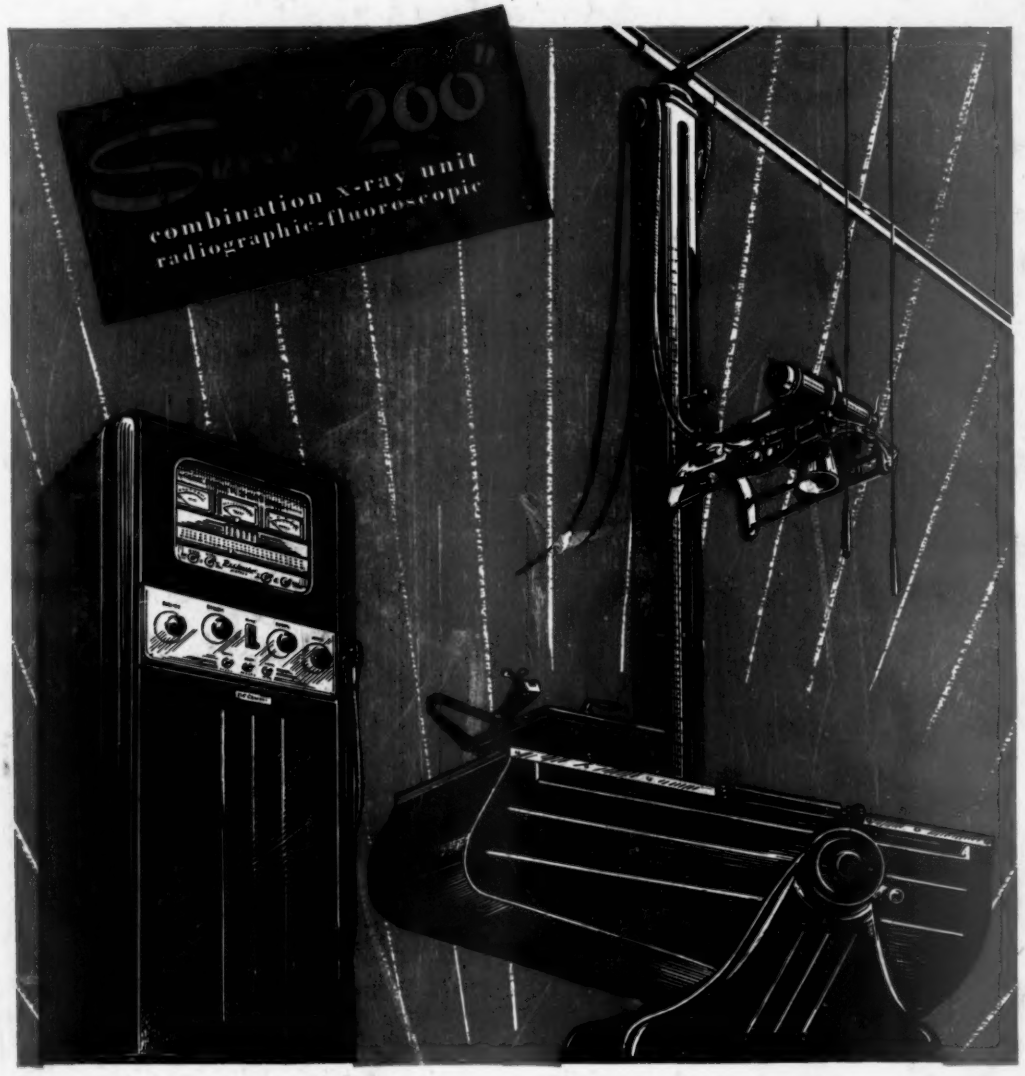
In bacterial vaginitis or cervicitis (whether occurring postoperatively or following childbirth or radiation), Triple Sulfa Cream* is rendering signally effective service in eradicating infection...healing mucosa...and restoring normal pH levels —primarily by virtue of its optimal bacteriostatic and bactericidal action at different specific pH levels. Healing time is frequently reduced by almost fifty percent with this simple, convenient therapy. Available at pharmacies everywhere.

***TRIPLE SULFA CREAM**—a pleasant, water-soluble, absorptive cream containing sulfathiazole, N'acetylsulfanilamide, N'benzoylsulfanilamide, and urea peroxide.*

*Trade-Mark

Ortho Pharmaceutical Corporation · Raritan, New Jersey

Makers of Gynecic Pharmaceuticals



In 1937 Picker introduced this first completely shockproof, self-contained combination x-ray apparatus delivering 200 MA over and under the table.

looked up to...

Today, its performance enhanced by a decade of constant improvement, the brilliant reputation of the Series "200" is world wide ... an apparatus *looked up to everywhere* as the criterion of excellence in x-ray equipment.

Picker

PICKER X-RAY CORPORATION
300 FOURTH AVE. · NEW YORK 10, N. Y.
WAITE M'F'G DIVISION · CLEVELAND, OHIO